MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11492

CERTIFICATE OF DEATH

11486

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
   d. STREET ADDRESS: 7056 Carroll Ave. Apt. 2
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy — Middle: — Last: Adams

4. DATE OF DEATH: Month: August — Day: 11 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 11, 1966

9. AGE (In years last birthday): — yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: 2 — Min.: 92

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Adams

14. MOTHER'S MAIDEN NAME: Mildred Rose Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Premature Delivery @ 23 wks gestation
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.

22a. SIGNATURE: Naor D. Stoehr — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Naor Stoehr, MD.

22d. ADDRESS: 7600 Carroll ave. Takoma Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8-15-66

23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium & Hospital

23d. LOCATION (City, town or county) (State): TakomaPark, Maryland

24. FUNERAL DIRECTOR — ADDRESS: H. S. Nelson, Washington San. & Hospital

25a. REC'D BY REGISTRAR — DATE: AUG 23 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

6-179040

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11493

CERTIFICATE OF DEATH

11487

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 4½ hours

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring. 16-2
d. STREET ADDRESS: 9201 New Hampshire Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON Sanitarium + Hospital

3. NAME OF DECEASED (Type or print): First IDA Middle Dulany Last ARMstrong

4. DATE OF DEATH: Month August Day 25 Year 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-13-80

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MissouRi

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin F. Dobyns

14. MOTHER'S MAIDEN NAME: Cordelia Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-46-2091-T

17. INFORMANT: Daughter — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Intra pontine Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
DUE TO (b): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
DUE TO (c):
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug, 1963 to Aug 25, 1966 that (I) (we) last saw the deceased alive on Aug 17 19 66 and that death occurred at 7:35 A.M. from causes and on the date stated above.

22a. SIGNATURE: Boris Rabkin — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 25, 1966

22c. PHYSICIAN'S NAME (Type): BORIS RABKIN, M.D.

22d. ADDRESS: 1019 Universal Blvd, Ext

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE THEREOF: 8/26/1966

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City or Town) (County) (State): Prince Georges Md.

24. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 354 Carroll St. N.W. Washington, D.C.

25a. REC'D BY REGISTRAR DATE: AUG 29 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11494

CERTIFICATE OF DEATH

11488

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: 20 mi.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
   d. STREET ADDRESS: 13207 Parkland Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-1

3. NAME OF DECEASED (Type or print): First: Lena — Middle: I. — Last: Ayers

4. DATE OF DEATH: Month: August — Day: 30 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 29, 1882

9. AGE (In years last birthday): 83 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Lexington, New York

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Frank Turk

14. MOTHER'S MAIDEN NAME: Addie Serro

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 219-22-1563A

17. INFORMANT: Mrs. Earl Hurley — Address: 13207 Parkland Dr. Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Insufficiency

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 1966 to 8/30, 1966, that (I) (we) last saw the deceased alive on Aug. 3 1966, and that death occurred at 1:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Belden R. Rea, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-30-1966

22c. PHYSICIAN'S NAME (Type): Belden R. Rea

22d. ADDRESS: Wheaton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sep. 1, 1966

23c. NAME OF CEMETERY OR CREMATORY: Brook View Cemetery

23d. LOCATION (City, town or county) (State): Rising Sun, Maryland

24. FUNERAL DIRECTOR: C. Glen Carter — Warner E. Pumphrey, Inc.

ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: AUG 31 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11495 **CERTIFICATE OF DEATH** 11489

1. PLACE OF DEATH
a. COUNTY Montgomery. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6631 - 81st St

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md. b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John 15-1
d. STREET ADDRESS 6631 - 81st St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Marvin Middle G. Last Barber
4. DATE OF DEATH Month Aug. Day 9 Year 1966
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 26, 1903
9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor
10b. KIND OF BUSINESS OR INDUSTRY Military Store
11. BIRTHPLACE (County & State, or foreign country) N. Car.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward A. Barber
14. MOTHER'S MAIDEN NAME Minnie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) Yes (If yes give war or dates of service) UNK.
16. SOCIAL SECURITY NO. 579-18-4046
17. INFORMANT Address Mary L. Barber, Wife Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure. — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Disease — 4 yrs
DUE TO (c) Diabetes Mellitus. — Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 1958, to August 9, 1966 that (I) (he) last saw the deceased alive on November 1965, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE Donald G. Ekman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED August 9, 1966
22c. PHYSICIAN'S NAME (Type) Donald G. Ekman
22d. ADDRESS 4720 Chevy Chase Drive, Chevy Chase.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 8/12/66
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln
23d. LOCATION (City, town or county) (State) Pr. Geo. Co., Md.

24. FUNERAL DIRECTOR W. W. Chambers Co Inc ADDRESS 8655 Ga. Ave Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE AUG 15 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11496

CERTIFICATE OF DEATH

11490

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON — 15-1
d. STREET ADDRESS: 12107 CENTERHILL ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DANIEL — Middle: KENNETH — Last: BARNES

4. DATE OF DEATH: Month: 8 — Day: 8 — Year: 19 66

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-7-66

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days: 1 — IF UNDER 24 HRS.: Hours: 9 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ROBERT ALLEN BARNES

14. MOTHER'S MAIDEN NAME: NANCY DELORSE EYLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MOTHER — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 776X
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 8/7, 1966, to 8/9, 1966, that (I) (~~we~~) last saw the deceased alive on 8/8 19 66, and that death occurred at 1:25 P.M., from causes and on the date stated above.

22a. SIGNATURE: James A. Davis Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/10/66

22c. PHYSICIAN'S NAME (Type): JAMES A. DAVIS JR

22d. ADDRESS: 8218 WISCONSIN AVE, BETHESDA

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/12/66

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (City or Town) (County) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

6-196189

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11497 **CERTIFICATE OF DEATH** 11491

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c LENGTH OF STAY IN 1b: 30 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d STREET ADDRESS: 111 Croydon Court
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: BARR
4. DATE OF DEATH: Month: August — Day: 6 — Year: 66

5 SEX: Female
6 COLOR OR RACE: Cauc
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 6, 1966
9 AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min. 30

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A
10b KIND OF BUSINESS OR INDUSTRY: N/A
11 BIRTHPLACE (County & State or foreign country): Bethesda, Montgomery, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: David A. Barr
14. MOTHER'S MAIDEN NAME: Vickie Lee Johnson

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): N/A
16. SOCIAL SECURITY NO: N/A
17 INFORMANT: David A. Barr, 111 Croydon Court, Silver Spring Address: Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Intraventricular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO (b): immaturity — [illegible]
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 765

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 6, 19 66, to Aug. 6, 19 66, that (I) (we) last saw the deceased alive on Aug. 6 19 66, and that death occurred at 1100 PM from causes and on the date stated above.

22a. SIGNATURE: J. I. Lynch M.D. — M.D ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 8, 1966
22c. PHYSICIAN'S NAME (Type): J. I. Lynch, M. D.
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b DATE THEREOF: 8/9/66
23c NAME OF CEMETERY OR CREMATORY: George Washington University School of Medicine
23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: S. H. Hines Funeral Home
2901 14th Street, N. W. Washington, D. C.

25a. REC'D BY REGISTRAR DATE: AUG 10 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11492

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Knoxville
d. STREET ADDRESS: Route 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Gary — Last: BEACHLEY

4. DATE OF DEATH: Month: August — Day: 15 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 15, 1927

9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: G. Dewey Beachley, Sr.

14. MOTHER'S MAIDEN NAME: Zillal Markoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1944-64

16. SOCIAL SECURITY NO.: 721-16-9445

17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laceration of Brain and head injuries severe — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), steting the underlying cause last.
DUE TO (b): Trauma from motorcycle accident
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Lost control of motor cycle and ran into Wall.

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 3 — 8/3 1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street.

20f. (City or town) Frederick (County) (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): John G. Ball M. D.

Address (Street, city, town, or county):

22. DATE SIGNED: Aug. 16, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/18/66

23c. NAME OF CEMETERY OR CREMATORY: St. Lukes Cemetery

23d. LOCATION (City, town or county) (State): Brownsville, Md.

24. FUNERAL DIRECTOR: Gladhill Funeral Home, Middletown, Md.
Douglas R. Snowden

ADDRESS:

25a. REC'D BY REGISTRAR DATE: AUG 18 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11499 11493

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 9days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAithersburg 15-1
d. STREET ADDRESS: 14 Peony Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ERNEST Middle: W Last: BEALL
4. DATE OF DEATH: Month: AUG Day: 10 Year: 1966
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/6/1877
9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country): Maryland-Mont. Co
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Francis C Beall
14. MOTHER'S MAIDEN NAME: Cordelia Watkins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO
17. INFORMANT: Son- Francis D. Beall Address 4215 Eddie Lee Fairfax Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Thrombosis left — INTERVAL BETWEEN ONSET AND DEATH: 9 days.
DUE TO (b): middle Cerebral Artery
DUE TO (c): Cerebral Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) ottended the deceased from August 1, 1966, to August 10, 1966 thot (I) (we) last sow the deceased alive on Aug 10 1966, and thot death occurred at 11A M, from causes ond on the date stoted above.

22a. SIGNATURE: J. Blaine Fitzgerald M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-10-66.
22c. PHYSICIAN'S NAME (Type): J. Blaine Fitzgerald
22d. ADDRESS: 8218 Wisconsin Ave. Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-13-66
23c. NAME OF CEMETERY OR CREMATORY: Park Lawn
23d. LOCATION (City or Town) (County) (State): Rockville Maryland

24. FUNERAL DIRECTOR: Ernest C. Gartner. ADDRESS: Gaithersburg Md.
25a. REC'D BY REGISTRAR DATE: AUG 12 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11500 **CERTIFICATE OF DEATH** 11494

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5804 Melvern Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hermann Middle: H. Last: Bergmann
4. DATE OF DEATH: Month: Aug Day: 3 Year: 19 66
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/22/1888
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months: 6 Days: 11
IF UNDER 24 HRS: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vice-Pres. Retired
10b. KIND OF BUSINESS OR INDUSTRY: Savings & Loan
11. BIRTHPLACE (County & State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry H. Bergmann
14. MOTHER'S MAIDEN NAME: Ida Myers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO: 577-07-2750
17. INFORMANT Address: Eleanor P. Bergmann-Wife -Same Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
(b): Arteriosclerotic Heart Disease — 2 years.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19 64 to August 3, 19 66, that (I) (saw) last saw the deceased alive on August 2 19 66, and that death occurred at 1:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: J. Blaine Fitzgerald M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-3-66.
22c. PHYSICIAN'S NAME (Type): J. Blaine Fitzgerald, M.D.
22d. ADDRESS: 8218 Wisconsin Ave Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/6/1966
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville Maryland
24. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 5 1966
25b. REGISTRAR'S SIGNATURE: Charles Grainger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11501

CERTIFICATE OF DEATH

11495

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 416 Royalton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest; Middle: ; Last: Bigler

4. DATE OF DEATH: Month: August; Day: 12; Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April ~~26~~ 22 1888

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Engineer (Stationary)

10b. KIND OF BUSINESS OR INDUSTRY: Apt. House, etc.

11. BIRTHPLACE (County & State, or foreign country): Switzerland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 577-10-2159

17. INFORMANT: Ida Bigler — Address: 416 Royalton Road, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic coma — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Metastatic carcinoma of liver — 1 year
DUE TO
(c): Adenocarcinoma, ascending colon — 6 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 4, 1966, to Aug 12, 1966, that (I) (we) last saw the deceased alive on Aug 12 1966, and that death occurred at 2 55 AM, from causes and on the date stated above.

22a. SIGNATURE: Raymond Bradshaw, Jr. M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 12, 1966

22c. PHYSICIAN'S NAME (Type): Raymond Bradshaw, Jr.

22d. ADDRESS: 345 University Blvd., S. S., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial Cremation

23b. DATE THEREOF: 8/15/66

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.

24. FUNERAL DIRECTOR: Clark & Wilson / Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

25a. REC'D BY REGISTRAR (DATE): AUG 16 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11502 — 11496

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5101 Ridgefield Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: WASH. D.C. — b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WASHINGTON D.C.
d. STREET ADDRESS: 4005 VAN NESS ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JENNIE — Middle: P. — Last: BOHANAN

4. DATE OF DEATH: Month: AUG. — Day: 24 — Year: 1966

5. SEX: FEMALE

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-30-1875

9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): PORT WASH. N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WM. HUITS.

14. MOTHER'S MAIDEN NAME: WILLELTA VAN CASTLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 479-60-1483

17. INFORMANT: MR. LOUIS A. HUITS — Address: 15th & PA. AVE N.W. WASH.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Artery Disease — 48 hours
DUE TO (c): Arteriosclerosis — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastric Disease Bon

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Jan. 1, 1966, to Aug. 24, 1966, that (I) (~~we~~) last saw the deceased alive on Aug. 22 1966, and that death occurred at 8:? M, from the causes and on the date stated above.

22a. SIGNATURE: Clifton R. Graver — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8/24/66

22c. PHYSICIAN'S NAME (Type): CLIFTON R. GRAVER — 22d. ADDRESS: 915 19th St NW Wash DC

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 8/27/66 — 23c. NAME OF CEMETERY OR CREMATORY: St. Joseph's Chapel — 23d. LOCATION (City, town or county) (State): WASH. CATHEDRAL WASH. D.C.

24. FUNERAL DIRECTOR: JOSEPH GAWLER SONS — ADDRESS: 5130 Wisc. Ave. N.W. WASH D.C.

25a. REC'D BY REGISTRAR — DATE: AUG 31 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11503

CERTIFICATE OF DEATH

11497

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 52 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 3810 Great Neck Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cecil — Middle: Austen — Last: BOLAM

4. DATE OF DEATH: Month: August — Day: 29 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2 Oct 1914

9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: Allied Science Industries

11. BIRTHPLACE (County & State, or foreign country): New York, N.Y.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Will Bolam

14. MOTHER'S MAIDEN NAME: (UNKNOWN)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): YES

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Elizabeth C. Bolam Address: 3810 Great Neck Ct. Alexandria, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of colon with wide spread metastasis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from July 7, 19 66, to August 29 19 66, that ☒ (we) last saw the deceased alive on August 29 19 66, and that death occurred at 5:03 PM, from causes and on the date stated above.

22a. SIGNATURE: W J Fouty — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 30 August 1966

22c. PHYSICIAN'S NAME (Type): W. J. FOUTY LCDR MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/2/1966

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

23d. LOCATION (City or Town) (County) (State): Arlington, Va.

24. FUNERAL DIRECTOR: John W. Maines ADDRESS: 520 South Washington St. Demaines Funeral Home Alexandria, Virginia

25a. RECD BY REGISTRAR DATE: SEP 2 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11504

CERTIFICATE OF DEATH

11498

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton
c. LENGTH OF STAY IN 1b 1/23 Adm.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Hills Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Washington, D.C. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON
d. STREET ADDRESS 4508 MacArthur Blvd. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Frances Middle F Last Boyle
4. DATE OF DEATH Month 8 Day 2 Year 1966

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4/18/16
9. AGE (In years last birthday) 50 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Keeping
10b. KIND OF BUSINESS OR INDUSTRY Natl. Dairy Co.
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Josephus Perry
14. MOTHER'S MAIDEN NAME Esther Knott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No —
16. SOCIAL SECURITY NO 577-03-6687
17. INFORMANT Thomas A. Boyle Address 4508 MacArthur

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 6 months
DUE TO
(b) Carcinoma of breast — 5 years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 50, to Aug 2, 1966 that (I) (we) last saw the deceased alive on Aug 1 1966, and that death occurred at 1:30 P.M. from causes and on the date stated above.

22a. SIGNATURE Robert E. Maher M.D. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Robert E Maher MD
22d. ADDRESS 1835 Eye St. N.W. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Aug 5, 1966
23c. NAME OF CEMETERY OR CREMATORY PARK LAWN CEM.
23d. LOCATION (City or Town) (County) (State) MONTGOMERY Co. MD.

24. FUNERAL DIRECTOR James E. DeVol ADDRESS 2224 Wisc. Ave. N.W.
25a. REC'D BY REGISTRAR DATE AUG 5 1966
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M S 63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11505

CERTIFICATE OF DEATH

11499

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 6 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 713 WHITAKER TERRACE

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 713 WHITAKER TERRACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNA — Middle: TERESA — Last: BRADY

4. DATE OF DEATH: Month: Aug — Day: 17 — Year: 1966

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 15, 1877

9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: MET. POLICE DEPT.

11. BIRTHPLACE (County & State, or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: BLASIUS BEHRLE

14. MOTHER'S MAIDEN NAME: ELIZABETH SCHOENHERR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 217-52-7516

17. INFORMANT: ROBT. HECKMAN — Address: 4410 HALLET ST ROCKVILLE, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 Hr
DUE TO (b): Arteriosclerotic Heart Disease — 8 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Tumor of Rt Kidney

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from ..... 19~~66~~ to death, 19....., that (I) (we) last saw the deceased alive on 17 Aug 1966, and that death occurred at 8.25 PM, from the causes and on the date stated above.

22a. SIGNATURE: Warren B. Burch M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 17 Aug 1966

22c. PHYSICIAN'S NAME (Type): WARREN B. BURCH

22d. ADDRESS: 405 A ST S.E. Wash. 3 D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/17/1966

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

23d. LOCATION (City, town or county) (State): Wash, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: JAS. T. RYAN, Inc. Jas T Ryan, Pr.

ADDRESS: 317 PARAVESE D.C.

25a. REC'D BY REGISTRAR (DATE): AUG 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11506 11500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2½ mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chevy Chase Nursing & Convalescent Cente

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Washington, D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 3811 Military Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Irene — Middle: E. — Last: Brady
4. DATE OF DEATH: Month: 8 — Day: 2 — Year: 1966
5. SEX: F
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-29-92
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J Barry
14. MOTHER'S MAIDEN NAME: Elizabeth Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Richard Brady (Son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Colon & Metastasis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this~~ hospital) attended the deceased from June, 1966, to Aug, 1966, that (I) (~~we~~) last saw the deceased alive on June 1966 and that death occurred at 7:20 AM, from causes and on the date stated above.

22a. SIGNATURE: William D Lind — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): William D. Lind
22d. ADDRESS: 9006 Colesville Rd Sil Sp. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 8-4-66
23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet
23d. LOCATION (City or Town) (County) (State): Wash. DC

24. FUNERAL DIRECTOR — ADDRESS: Thos P Hanlon
HANLON FUNERAL HOME Wash D.C.

25a. REC'D BY REGISTRAR — DATE: AUG 9 1966
25b. REGISTRAR'S SIGNATURE

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11507

CERTIFICATE OF DEATH

11501

Cleared & Cornet 8/21 - Dupl Rec'd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN To: ??
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: MARYLAND — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 9722 Oulver Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Hook — Last: BREEN

4. DATE OF DEATH: Month: Aug — Day: 21 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 1, 1883

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months 6, Days 20 — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bancres Hook

14. MOTHER'S MAIDEN NAME: Nellie Prince

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Mrs. Roxanne Hume-Daughter-Same Item#2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs
DUE TO (b): Hypertensive Vascular Disease — Many Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): (Autopsy Report Not Available at Signing)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 57, to Aug 21, 1966, that (I) ~~(me)~~ last saw the deceased alive on Aug 21 1966, and that death occurred at 430 PM, from causes and on the date stated above.

22a. SIGNATURE: James W. Egan M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/22/66

22c. PHYSICIAN'S NAME (Type): James W. Egan, M.D.

22d. ADDRESS: 7720 Wisconsin Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit

23b. DATE THEREOF: 8/22/1966

23c. NAME OF CEMETERY OR CREMATORY: Oaklawn Cemetery

23d. LOCATION (City or Town) (County) (State): Chicago Illinois

24. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11508 **CERTIFICATE OF DEATH** 11502

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
Resmor Hospital
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN Ib: 7WKs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Resmor Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE
b. COUNTY
4515 Dorset Ave
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase Md.
d. STREET ADDRESS: 5721 Grosvenor Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Harriet Middle M. Last Brown
4. DATE OF DEATH: Month Aug Day 26 Year 1966

5. SEX: Fe
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 8, 1880
9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: — —
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON D.C. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Otha Muncaster
14. MOTHER'S MAIDEN NAME: MARY Rittenhouse Nourse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. — —
17. INFORMANT: MRS. MARY CARRUTHERS Address: BETH-MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): PNEUMONIA, RIGHT LUNG — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS
DUE TO (b): ARTERIOSCLEROSIS, GENERAL — 2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN, 1963 to Aug 26, 1966, that (I) (we) last saw the deceased alive on Aug. 26 1966, and that death occurred at 2:40 P.M., from causes and on the date stated above.

22a. SIGNATURE: Leo M. Curtis M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: AUG. 26, 1966
22c. PHYSICIAN'S NAME (Type): LEO M. CURTIS
22d. ADDRESS: 8218 WISCONSIN AVE, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/29/66
23c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK
23d. LOCATION (City or Town) (County) (State): WASH. D.C.

24. FUNERAL DIRECTOR: Joseph Dawley Sons ADDRESS: 5130 Wisconsin Ave
25a. REC'D BY REGISTRAR DATE: AUG 31 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11509

CERTIFICATE OF DEATH

11503

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus — 15-1
d. STREET ADDRESS: 26120 Mt. Vernon Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Perlle — Middle: N. --- — Last: Brown

4 DATE OF DEATH: Month: 8 — Day: 15 — Year: 19 66

5 SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-9-~~22~~ 13

9. AGE (In years last birthday): 53 ~~53~~ yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife ---

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State or foreign country): Washington

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Conrad J. Nelson

14. MOTHER'S MAIDEN NAME: Axelina Kovick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO: 546-18-4507

17. INFORMANT: Hospital Admission Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis, liver — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/5, 1966, to 8/15, 1966 that (I) (we) last saw the deceased alive on 8/15 19 66, and that death occurred at 4:35PM, from causes and on the date stated above.

22a. SIGNATURE: Arthur F. Woodward — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/16/66

22c. PHYSICIAN'S NAME (Type): A.F. Woodward, M. D.

22d. ADDRESS: Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug.19,1966

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) (County) (State): Ft. Myer, Virginia

24. FUNERAL DIRECTOR: Olin L. Molesworth, ADDRESS: Damascus, Md.

25a. REC'D BY REGISTRAR DATE: AUG 22 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11510

CERTIFICATE OF DEATH

11504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and [illegible] event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General, Olney, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
d STREET ADDRESS: Rt. 1, Box 152
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Mary — Middle: Ganelle — Last: Burroughs

4 DATE OF DEATH: Month: 8 — Day: 24 — Year: 19 66

5 SEX: F
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 4/13/02
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. Wife
10b KIND OF BUSINESS OR INDUSTRY: Home
11 BIRTHPLACE (County & State, or foreign country): Md.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Andrew Brooke Arnold
14 MOTHER'S MAIDEN NAME: Emma Wade

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17 INFORMANT: Clifton E. Burroughs — Address: Same as 7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiorespiratory failure
DUE TO (b): with generalized lung abdominal metastases — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1750

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from March, 19 66, to 8/24, 19 66 that (I) (~~we~~) last saw the deceased alive on 8/20 19 66 and that death occurred at 1:25 P.M. from causes and on the date stated above.

22a. SIGNATURE: Arthur F. Woodward — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 8/24/66
22c. PHYSICIAN'S NAME (Type): Arthur F. Woodward
22d. ADDRESS: Rockville - Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 8-27-66
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
23d. LOCATION (City or Town) (County) (State): Ga. Ave. Silver Spring, Md.

24 FUNERAL DIRECTOR: Francis H. Barber — ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE: AUG 29 1966
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11511 — 11505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: 3 months
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 305 Lanark XXXXX Way — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Linda — Middle: Hardy — Last: Carmichael

4. DATE OF DEATH: Month: August — Day: 16 — Year: 19 66

5. SEX: F — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-[illegible]-06

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired XXXXXXX

10b. KIND OF BUSINESS OR INDUSTRY: Gray, Kessinger Co.

11. BIRTHPLACE (County & State, or foreign country): [illegible]

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: [illegible] Carmichael

14. MOTHER'S MAIDEN NAME: Elizabeth Hamrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: Yes

17. INFORMANT: Jane Simone Carmichael — Address: 305 Lanark Way, S. S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: Mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardiac carcinoma of pancreas — Mos.
DUE TO (c):

157X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19 66, to 8-16, 19 66, that (I) (we) last saw the deceased alive on [illegible] 19 66, and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: Albert H. Grollman M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑ — 22b. DATE SIGNED: 8/16/66

22c. PHYSICIAN'S NAME (Type): ALBERT H. GROLLMAN — 22d. ADDRESS: 1106 SPRING ST. SILVER SPRING

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Aug. 19, 1966 — 23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park — 23d. LOCATION (City, town or county) (State): Falls Church, Virginia

24. FUNERAL DIRECTOR: Clark E. Wilson, Warner E. Pumphrey, Inc. — ADDRESS: Clark & Wilson 8434 Georgia Ave Silver Spring, Md. — 25a. REC'D BY REGISTRAR DATE: AUG 19 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11512 — 11506

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5612 Glenwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: CATHERINE — Middle: A. — Last: CARR
4 DATE OF DEATH: Month: August — Day: 15, — Year: 19 66

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 1, 1911
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months: 6 Days: 14
IF UNDER 24 HRS.: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Benjamin Redmond
14. MOTHER'S MAIDEN NAME: Margaret Carmody

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO: 215-38-6280
17. INFORMANT Address: Edward M. Carr-Husband-Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO
(b): Metastatic Carcinoma of Liver — 6 mos
DUE TO
(c): Carcinoma of Sigmoid Colon — 18 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1966, to Aug 13, 1966, that (I) (we) last saw the deceased alive on Aug 13 1966, and that death occurred at 7:35 A.M., from causes and on the date stated above.

22a. SIGNATURE: James W Egan M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-15-66
22c. PHYSICIAN'S NAME (Type): JAMES EGAN, M.D.
22d ADDRESS: ~~7720 Wisconsin Ave.~~ 5415 Cedar Lane 206C, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 8/18/1966
23c NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d LOCATION (City or Town) (County) (State): Silver Spring Maryland

24. FUNERAL DIRECTOR: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a RECD BY REGISTRAR DATE: AUG 17 1966
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11513 — 11507

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Valley Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 7030 ARMAT DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE — Middle L. — Last CARVER

4. DATE OF DEATH: Month August — Day 13 — Year 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 27, 1877
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months 3 — Days 16 — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES LEGG
14. MOTHER'S MAIDEN NAME: CORNELIA TRIPLETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: MRS. SELMA POWERS — Address 7030 Armat Dr. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): METASATIC CARCINOMIA OF THE COLON, LIVER — INTERVAL BETWEEN ONSET AND DEATH: 6 Months
DUE TO
(b): CARCINOMA OF RIGHT BREAST — 5 Years
DUE TO
(c): G
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1956, 19__ to date, 19__, that (I) (we) last saw the deceased alive on January 1966, and that death occurred at 2:15 AM from causes and on the date stated above.

22a. SIGNATURE: John B. Ball M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-13-66
22c. PHYSICIAN'S NAME (Type): JOHN BALL, M.D.
22d. ADDRESS: BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8-16-66
23c. NAME OF CEMETERY OR CREMATORY: IVY HILL
23d. LOCATION (City or Town) (County) (State): UPPERVILLE VA.

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY
ADDRESS: BETHESDA, MD.
25a. REC'D BY REGISTRAR DATE: AUG 19 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M 11514 — 11508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM II/59

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 6 Days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Garden Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 307 - Great Falls Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gretchen — Middle WANNER — Last Casey

4. DATE OF DEATH: Month August — Day 10 — Year 1966.

5. SEX: Fe.

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 29-1911

9. AGE (If years last birthday): 55 yrs
IF UNDER 1 YEAR: Months 2 Days 11
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania -

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Albert WANNER

14. MOTHER'S MAIDEN NAME: AGnes Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 219-46-9908

17. INFORMANT: Husband — Address: Same as Item 2.
Thomas G. Casey

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): TERMINAL BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CIRRHOSIS OF LIVER — 6 MONTHS
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CARCINOMA LEFT BREAST

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 2, 1956 to Aug 10, 1966 that (I) (we) last saw the deceased alive on Aug. 10 1966, and that death occurred at 2:25 P. M. from the causes and on the date stated above.

22a. SIGNATURE: Robert G. Angle M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Aug. 10, 1966

22c. PHYSICIAN'S NAME (Type): ROBERT G. ANGLE

22d. ADDRESS: 5009 Del Ray Ave. Bethesda, Maryland

23a. BURIAL, CREMATION REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8-11-66

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

23d. LOCATION (City, town, or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY

ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 12 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11515

CERTIFICATE OF DEATH

11509

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg.
d. STREET ADDRESS: Route 2 Box 246.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Chase

4. DATE OF DEATH: Month: 8 — Day: 8 — Year: 1966

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/8/66

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: 10 Min.: 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lee Howard Chase

14. MOTHER'S MAIDEN NAME: Sandra Leigh Chase

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Chart. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:
776 x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: Richard J. Hollander — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Richard J. Hollander

22d. ADDRESS: 1110 Spring St, Silver Springs,

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/11/66

23c. NAME OF CEMETERY OR CREMATORY: Mt zion Cemetery

23d. LOCATION (City or Town) (County) (State): Mt Zion, Montg. Md

24. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md

25a. REC'D BY REGISTRAR DATE: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

6/22/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23b Film 42/9 8/10/66 mh

11516

CERTIFICATE OF DEATH

11510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 80 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
d. STREET ADDRESS: 6116 Temple Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Waldeman — Middle: Nichlous — Last: CHRISTENSEN

4. DATE OF DEATH: Month: August — Day: 2 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 16, 1904

9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months: 5 Days: 16
IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (County & State, or foreign country): English Lake, Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Christian Christensen

14. MOTHER'S MAIDEN NAME: Anna Lund

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
If yes give war or dates of service: 1925-1955

16. SOCIAL SECURITY NO: 103-30-7820

17. INFORMANT: Mrs. Lucille Christensen, 6116 Temple St.
Address: Bethesda Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis, acute
DUE TO
(b): Carcinoma of colon
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m.; 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from May 16, 1966, to Aug. 2, 1966, that ~~I~~ (we) last saw the deceased alive on Aug. 2 1966, and that death occurred at 1035 P M, from causes and on the date stated above.

22a. SIGNATURE: Donald K. Roeder M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3 August 1966

22c. PHYSICIAN'S NAME (Type): Donald K. Roeder, M. D.

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug.5,1966

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR ADDRESS: R. A. Pumphrey Funeral Home
7557 Wisconsin Ave., Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 5 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18&21 Film 381 9-29

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11511

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a COUNTY Montgomery MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San't Hosp

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE D.C. b COUNTY
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Washington
d STREET ADDRESS 4707 Conn. Ave. N.W.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First HENRY Middle CLEPATCH Last
4 DATE OF DEATH Month 8 Day 28 Year 1966
5 SEX M
6 COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 7-1-01
9 AGE (In years last birthday) 65 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) Russia
12 CITIZEN OF WHAT COUNTRY? Amer.
13 FATHER'S NAME Joseph Clepatch
14 MOTHER'S MAIDEN NAME Edith Fetterman
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW I
16 SOCIAL SECURITY NO 577 54 3158
17 INFORMANT Address Hosp. record

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute myocardial failure
DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
42:1
(b) Coronary artery heart disease
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county) Wheaton
22. DATE SIGNED 8/29/1966

23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b DATE THEREOF 8-30-66
23c NAME OF CEMETERY OR CREMATORY Ohev Sholom-Talmud Torah Cem.
23d LOCATION (City or Town) (County) (State) Washington, DC

24. FUNERAL DIRECTOR Bernard Danzansky & Sons ADDRESS Washington DC
25a RECD BY REGISTRAR DATE AUG 31 1966
25b REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil (Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11518

CERTIFICATE OF DEATH

11512

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: New Hampshire
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DOVER
d. STREET ADDRESS: 14 RIVERDALE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Max — Middle: — Last: Cohen
4. DATE OF DEATH: Month: August — Day: 6 — Year: 1966

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/10/97
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: DRESSES
11. BIRTHPLACE (County & State, or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USSR

13. FATHER'S NAME: JACOB COHEN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — NONE
16. SOCIAL SECURITY NO: 015-12-6778
17. INFORMANT: HENRY SOLOMON — 14103 Address ORVALE ST. ROCKVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinoma head & pancreas
DUE TO (c):
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 20, 1966, to Aug 6, 1966, that (I) (we) last saw the deceased alive on Aug 6 1966, and that death occurred at 5:50 P.M. from causes and on the date stated above.

22a. SIGNATURE: Gene Cohen M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 6, 66
22c. PHYSICIAN'S NAME (Type): GENE COHEN
22d. ADDRESS: 1106 - SPRING ST. SILVER SPRING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/8/66
23c. NAME OF CEMETERY OR CREMATORY: SHARON MEM. PARK
23d. LOCATION (City or Town) (County) (State): SHARON - MASS.

24. FUNERAL DIRECTOR: GOLDBERG FUNERAL HOME ST. N.W.
ADDRESS: 4217-9
25a. RECD BY REGISTRAR DATE: AUG 9 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11519

CERTIFICATE OF DEATH

11513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 12 h. 20 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4008 Sprucewood
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Carl — Last: Coiro
4. DATE OF DEATH: Month: 8 — Day: 18 — Year: 1966
5. SEX: M.
6. COLOR OR RACE: Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/8/97
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / M.n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Izmir - Turkey
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Constantine Cois
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: UNKNOWN
17. INFORMANT: Constantine Coiro Address 4944 Hampton Lane Bethesda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Liver failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Metastatic Carcinoma — 4 mon Ht
DUE TO
(c): Carcinoma of bronchus — 6 mon Ht.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 1 MARCH, 1966, to 18 AUG, 1966, that (I) ~~(we)~~ lost saw the deceased alive on 18 AUG 1966, and that death occurred at 7:34 P.M. from causes and on the date stated above

22a. SIGNATURE: Michael Mendeloff M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-19-66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 20 AUGUST 1966
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN
23d. LOCATION (City or Town) (County) (State): BLADENSBURG Md.

24. FUNERAL DIRECTOR: RINALDI FUNERAL HOME
ADDRESS: 740 Eighth St. N.E. Washington DC 20016
25a. RECD BY REGISTRAR DATE: AUG 22 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11520 — 11514

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): German Town
c. LENGTH OF STAY IN 1b: 3 Months.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Maryvander Home of Rest, Inc.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 530 Whittier St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mabel — Middle: Irene — Last: Collins
4. DATE OF DEATH: Month: 8 — Day: 3 — Year: 1966
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 3/3/1881
9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): N. Y. C.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: James Harry Fenman
14. MOTHER'S MAIDEN NAME: Elizabeth Kirby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 579-28-7013
17. INFORMANT: L. L. Scaife, LPN. — Address: Germantown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years.
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): — DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/33, 1966, to 8/3, 1966, that (I) saw last saw the deceased alive on 8/3 1966, and that death occurred at 11:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James J. Kerr — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/3/66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Aug-6-1966 — 23c. NAME OF CEMETERY OR CREMATORY: Glenwood — 23d. LOCATION (City, town or county) (State): Ft. — D. C.

24. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 4th & Carroll St. N.W. Washington, D.C.
25a. REC'D BY REGISTRAR DATE: AUG 8 1966 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11521

CERTIFICATE OF DEATH

11515

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b COUNTY: MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d STREET ADDRESS: 11202 Carroll Place
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First DARRELL — Middle D. — Last CONN
4 DATE OF DEATH: Month Aug. — Day 14, — Year 19 66

5 SEX: MALE
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 4/19/11
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months 3 — Days 25
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN
10b KIND OF BUSINESS OR INDUSTRY: WASH. Gas Light Co.
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CALVIN L. CONN
14 MOTHER'S MAIDEN NAME: MAUD RITTENHOUSE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes give war or dates of service): WW II
16 SOCIAL SECURITY NO: Unknown
17 INFORMANT: Lucille Conn — Address: WIFE — SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOGENIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO (b): METASTESIS TO BRAIN — 2 mos
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/7, 1966, to 8/14, 1966, that (I) (we) last saw the deceased alive on 8/14 1966, and that death occurred at 10:45 P.M, from causes and on the date stoted above.

22a. SIGNATURE: John E. Everett M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/15/66
22c. PHYSICIAN'S NAME (Type): JOHN E. EVERETT
22d. ADDRESS: 9400 Conn. Av. Kensington

23a. BURIA., CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/18/1966
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
23d. LOCATION (City or Town) (County) (State): Arlington Virginia

24. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 17 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11522 — 11516

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 26 da
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN & HOSP

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Dist of Col — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON D.C.
d. STREET ADDRESS: 7924 16th St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAWRENCE — Middle FARWELL — Last COOK

4. DATE OF DEATH: Month 8 — Day 23 — Year 1966

5. SEX: M — 6. COLOR OR RACE: WH — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 6/21/00 — 9. AGE (In years last birthday): 66 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Forester — Assist to Director National Park Service
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (County & State, or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FERDINAND COOK
14. MOTHER'S MAIDEN NAME: SUSAN Emmerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWI ARMY
16. SOCIAL SECURITY NO.: 358-22-7840
17. INFORMANT: Grace W. Cook — Address: 7924 16th St. Washington D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recent Bilateral Cerebral Infarction Rt. side — Massive in — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Generalized arteriosclerosis — 5 yrs.
DUE TO (c): Diabetes Mellitus. — 10 yrs.
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hemorrhage into basal ganglia & internal capsule on right

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-4, 1966, to 8/23, 1966, that (I) (we) last saw the deceased alive on 8/23 1966, and that death occurred at [illegible] M, from causes and on the date stated above.

22a. SIGNATURE: N Shoemaker MD — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-24-66
22c. PHYSICIAN'S NAME (Type): Norman C. Shoemaker. M.D
22d. ADDRESS: 811 Dale Drive; Silver Spring, Md 20910

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: Aug. 24, 1966
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.

24. FUNERAL DIRECTOR: John B. Thomas [illegible] Hum — ADDRESS: 8434 Georgia Avenue
Warner C. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: AUG 26 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11523

CERTIFICATE OF DEATH

11517

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 R
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 308 S. Waterford Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: M. — Last: Coon

4. DATE OF DEATH: Month: 8 — Day: 29 — Year: 1966

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 6-3-15

9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: — — McCormick

14. MOTHER'S MAIDEN NAME: Josephine Burke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service): — — —

16. SOCIAL SECURITY NO: — — —

17. INFORMANT: Henry G. Coon - See Item "2." — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic breast carcinoma
DUE TO
(b): to brain, lungs, liver, multiple
DUE TO
(c): lymph nodes and bones
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
I. C. X
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-25-65, 19__, to 8-29-66, 19__, that (I) (we) last saw the deceased alive on 8/29/66 19__, and that death occurred at 7:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: Henry C. Scruggs M.D. — M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 8/30/66

22c. PHYSICIAN'S NAME (Type): Henry C. Scruggs M.D.

22d. ADDRESS: 5413 Cedar La Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-1-1966

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.

23d. LOCATION (City or Town) (County) (State): Silver Spring Md.

24. FUNERAL DIRECTOR: Joseph Gawler Son — ADDRESS: Wash. D.C.

25a. REC'D BY REGISTRAR DATE: SEP 6 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11524

CERTIFICATE OF DEATH

11518

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN this city: 3days/13hrs./30
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10126 Tenbrook Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Walter — Last: Corridon

4. DATE OF DEATH: Month: August — Day: 21 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-14-92

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Plumbing Inspect

10b. KIND OF BUSINESS OR INDUSTRY: Wash. Sub. Sen. Comm.

11. BIRTHPLACE (County & State, or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John J. Corridon

14. MOTHER'S MAIDEN NAME: Emma Carrick

10126 Tenbrook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 579-30-9736

17. INFORMANT: Annie Corridon — Hospital Records
Address: Silver Spring 7600 Carroll Ave. Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4days
DUE TO (b): Arteriosclerotic cardio-vascular disease — unknown
DUE TO (c): Diabetes mellitus — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 8-17, 19 66, to 8-21, 19 66 that (I) ~~(we)~~ last saw the deceased alive on 8-20 19 66, and that death occurred at 3:30 A M, from causes and on the date stated above.

22a. SIGNATURE: Eino Magi — M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-21-1966

22c. PHYSICIAN'S NAME (Type): EINO MAGI

22d. ADDRESS: 831 Univ. Blvd. E., Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 23, 1966

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION (City or town) (County) (State): Prince Georges Co., Md.

24. FUNERAL DIRECTOR: Glen Carter, Warner E. Pumphrey, Inc.
ADDRESS: 8434 Ga. Ave. Silver Spring, Md

25a. REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11525 — 11519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 1yr 2 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheaton Nursing Home 11901 Georgia Ave.

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4207 Rosemary St — e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: James — Middle: Benjamin — Last: Crabbe

4. **DATE OF DEATH**: Month: August — Day: 13 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: July 26 1878

9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Rental agent

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Henry Crabbe

14. MOTHER'S MAIDEN NAME: Sarah Courtney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.: 220-44-1906

17. **INFORMANT**: Jeanette Snell — Address: 5901 Durbin Rd. Kenwood Park, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Peripheral and Cardiac Collapse — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Rupture abdominal aneurysm — INTERVAL BETWEEN ONSET AND DEATH: Same

DUE TO

(c): Atherosclerosis aorta

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized atherosclerosis; Senescence; old CVA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from ..... 19..., to Aug 13 ..... 1966, that (I) (~~we~~) last saw the deceased alive on Aug 13 ..... 1966, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas E. Curtin M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Thomas E. Curtin

22d. ADDRESS: 4600 Connecticut Ave N.W.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 8/16/66

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: The H. Hines Co. — ADDRESS: 2901 14th ST. N.W.

25a REC'D BY REGISTRAR: AUG 16 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2a filed 8/15/66 mh

11526

CERTIFICATE OF DEATH

11520

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Rhode Island
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Kingstown
d. STREET ADDRESS: Forest Park 79 North Kingstown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Sada — Middle Katherine — Last CROUSE

4 DATE OF DEATH: Month August — Day 11 — Year 19 66

5 SEX: Female

6 COLOR OR RACE: Cauc.

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH: Sept. 12, 1901

9 AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months 10 Days 9
IF UNDER 24 HRS.: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11 BIRTHPLACE (County & State or foreign country): Rising Sun, Indiana

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Dugle

14. MOTHER'S MAIDEN NAME: Mary Niemier

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes give war or dates of service): N/A

16 SOCIAL SECURITY NO.: 316 32 5402

17 INFORMANT: Greenwood — Address: Indiana
Mr. Eugene A. Crouse, 439 Park Drive/

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Aortic Stenosis and Mitral Stenosis
DUE TO
(c): Rheumatic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 3, 1966, to Aug 11, 1966, that (I) (we) last saw the deceased alive on Aug 11 19 66, and that death occurred at 210P M, from causes and on the date stated above.

22a SIGNATURE: Donald H. Gaylor — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: Aug. 12, 1966

22c. PHYSICIAN'S NAME (Type): Donald H. Gaylor, M. D.

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: TRANSIT 8-12-66

23c. NAME OF CEMETERY OR CREMATORY: Rising Sun Cemetery

23d. LOCATION (City or Town) (County) (State): Rising Sun, Indiana

24. FUNERAL DIRECTOR: R. A. Pumphrey Funeral Home — ADDRESS: 7557 Wisconsin Ave., Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: AUG 15 1966

25b REGISTRAR'S SIGNATURE: J. Charles Juegan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Item 20 Film 380 8-29-66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11521

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4757 Chevy Chase Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JAMES — Middle: Edward — Last: CROWELL
4. DATE OF DEATH: Month: August — Day: 13 — Year: 1966
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 15, 1942
9. AGE (In years last birthday): 24 yrs — IF UNDER 1 YEAR: Months: 0, Days: 28 — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reproduction
10b. KIND OF BUSINESS OR INDUSTRY: Xerox, Inc.
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Edward Crowell
14. MOTHER'S MAIDEN NAME: Veemillion
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Lucille Crowell. Address: (Mother) odd same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: instant
DUE TO
(b): Burn diffuse severe
DUE TO
(c): Automobile accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 819.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Rte 705, car at high speed hit abutment of bridge, turned over and caught fire
20c. TIME OF INJURY Month Day Year Hour: 11 p.m. Aug 13 66
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Highway
20f. (City or town) (County) (State): Hyattstown Montg. Md

21. **I certify** that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W Murphy MD
EXAMINER'S NAME (Type): W. S. Murphy
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county): Rockville, Md.

22. DATE SIGNED: 14 Aug 66

23a. BURIAL CREMATION REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 8-15-66
23c. NAME OF CEMETERY OR CREMATORY: Monte Vista Cemetery
23d. LOCATION (City or Town) (County) (State): Bluefield, W. Va.

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: AUG 19 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Jogge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 Hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11528 Item 3 Film G383 11/30/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11522

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seneca
c. LENGTH OF STAY IN 1b: 1hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Seneca Creek.

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 120 Tulip Drive.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Thomas Middle Edward Last Cullers.

4 DATE OF DEATH: Month August Day 21 Year 1966

5 SEX: M.

6 COLOR OR RACE: W.

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: May 10 1946

9 AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR: Months 3 Days 11
IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ??

10b KIND OF BUSINESS OR INDUSTRY: ??

11 BIRTHPLACE (State or foreign country): West Virginia

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jesse Cullers

14 MOTHER'S MAIDEN NAME: Gladys Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16 SOCIAL SECURITY NO: Unknown

17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Asphyxia. from Drowning — INTERVAL BETWEEN ONSET AND DEATH: 5 M.A.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Boat Swamped in creek. Couldn't Swim.

20c TIME OF INJURY Month, Day Year Hour a.m.: 345 8/21 1966

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Creek

20f (City or Town) Seneca (County) Mont (State) Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): John G. Ball, M. D.

22. DATE SIGNED: 8/21/66

Address (Street, city, town, or county): Bethesda, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/24/66

23c NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d LOCATION (City or Town) (County) (State): Mathias, W. Va.

24 FUNERAL DIRECTOR: Robert A. Pumphrey

ADDRESS: Bethesda, Md.

25a REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11529

CERTIFICATE OF DEATH

11523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 16 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 8221 GARLAND AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: VERENA — Middle: E. — Last: CURRAN
4. DATE OF DEATH: Month: AUGUST — Day: 22 — Year: 1966
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-20-96
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): SOUTH DAKOTA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: WILLIAM HENRICH
14. MOTHER'S MAIDEN NAME: MARY REISER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Rec M. CURRAN — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Arteriosclerotic Cardio-Vascular Disease
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1966 to Aug, 1966, that (I) (we) last saw the deceased alive on Aug 22 1966, and that death occurred at 7:30 P M, from causes and on the date stoted above.

22a. SIGNATURE: Bernard A Fitzgerald M.D — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 8-22-66
22c. PHYSICIAN'S NAME (Type): BERNARD A. FITZGERALD
22d. ADDRESS: 217 UNIV. BLVD E SIL SP. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8-24-66
23c. NAME OF CEMETERY OR CREMATORY: GATE-OF-HEAVEN CEM.
23d. LOCATION (City or Town) (County) (State): SILVER SPRING, MARYLAND
24. FUNERAL DIRECTOR: Francis J Collins — ADDRESS: Wash DC 3821-14th St NW
25a. REC'D BY REGISTRAR DATE: AUG 24 1966
25b. REGISTRAR'S SIGNATURE: Charles Jr

1

Cleared = Dr Ruth 8/27/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film 3000 9/8/66 vb & 9

11530

CERTIFICATE OF DEATH

11524

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then (please) remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton Chevy Chase
d. STREET ADDRESS: 2304 Elm St. Wheaton, Virginia Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lyda — Middle: M — Last: Dallas
4. DATE OF DEATH: Month: August — Day: 25 — Year: 1966

5. SEX: F
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-4-78
8a. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Calf.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs Harold Graves h. 4816 Grantham St. Chevy Chase Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic cerebrovascular disease — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Diabetes mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture right hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MED CAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell in nursing home while walking
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: July 28 1966
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): nursing home
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from _____, 19__ to Aug 25, 1966 that (I) ~~(was)~~ lost saw the deceased alive on 25 Aug 1966, and that death occurred at 2:15 M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 27 66
22c. PHYSICIAN'S NAME (Type): WALTER E. GOOZH MD
22d. ADDRESS: 2390 GLENMONT CIR WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 8-29-66
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Princes Georges

24. FUNERAL DIRECTOR — ADDRESS: Wilhelm Funeral Home 4308 Suitland Rd. Suitland
28a. REC'D BY REGISTRAR: Md. AUG 31 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11531

CERTIFICATE OF DEATH

Item #11 infor taken from birth cert. 8/31/66 ew

11525

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 days

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital of Silver Spring
d. STREET ADDRESS: 9312 Piney Branch Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SUSAN Middle: Elizabeth Last: DAVIDSON

4. DATE OF DEATH: Month: Aug. Day: 17 Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/19/66

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: Days: 2
IF UNDER 24 HRS.: Hours: + Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Montgomery, Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert G. Davidson

14. MOTHER'S MAIDEN NAME: Alice Gnagey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Father
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, bilateral
DUE TO (b): Aspiration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Prematurity

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from August 9, 1966, to August 17 1966, that (I) (~~we~~) last saw the deceased alive on August 17, 1966, and that death occurred at 11:35 M, from the causes and on the date stated above.

22a. SIGNATURE: Stanley H. Steinberg, MD M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/19/66

22c. PHYSICIAN'S NAME (Type): Stanley H. Steinberg

22d. ADDRESS: 1040 University Blvd. E. Langley Park

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/20/66

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (City, town or county) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR: Myron Wheeler
ADDRESS: 1331 Rockville Pike, Rockville, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

C-21598

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11532

CERTIFICATE OF DEATH

11526

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY Co. MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 9908 EDGEHILL LA.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSE Middle - Last de GRACIA

4. DATE OF DEATH: Month 8 Day 7 Year 1966

5. SEX: M

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-1-05

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: Capitol Power Plant

11. BIRTHPLACE (County & State, or foreign country): SPAIN

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jose de Gracia

14. MOTHER'S MAIDEN NAME: (unknown) Miranda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): 1927-1932

16. SOCIAL SECURITY NO.: 579-14-5660

17. INFORMANT: Eugenia deGracia Address: 9908 Edgehill Lane Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute coronary thrombosis, with myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hrs

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960, 19__, to August 7, 1966, that (I) (we) last saw the deceased alive on August 7 1966, and that death occurred at 8:06 PM, from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter, Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 7, 1966

22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr M.D

22d. ADDRESS: 9301 Colesville Rd., Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 11, 1966

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: John B. Thomas Warner E. Pumphrey, Inc.

ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: AUG 11 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 M

OK with Dr. Ball - coroner

De Gracia, Jose -

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11533

CERTIFICATE OF DEATH

11527

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 5 hrs + 20 mins
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SANITARIUM & HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D. C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXXX Washington +/- 5
d. STREET ADDRESS: 1339 KALMIA ROAD N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREDERICK Middle FERDINAND Last DICK

4. DATE OF DEATH: Month AUGUST Day 6 Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-15-92

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED GOV. WORKER
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (County & State, or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A. AMERICAN

13. FATHER'S NAME: ERNST DICK

14. MOTHER'S MAIDEN NAME: CHRISTINE REINACHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO: 578-62-3237

17. INFORMANT: Ruth E. Dick — Address: 1339 Kalmia Rd. N. W., Wash., D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): UREMIA - CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS.
DUE TO (b): HYDRONEPHROSIS BILATERAL URETERAL CONGRESSION — 3 MONTHS.
DUE TO (c): PROSTATIC CARCINOMA WITH METASTASES — 20 MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 11K

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from JULY, 1953 to AUGUST 6, 1966, that (I) (~~we~~) last saw the deceased alive on AUGUST 6 1966, and that death occurred at 4:35 A.M., from causes and on the date stated above.

22a. SIGNATURE: Robert L. Krichmar M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: AUGUST 6 1966

22c. PHYSICIAN'S NAME (Type): ROBERT L. KRICHMAR

22d. ADDRESS: 7733 ALASKA AVENUE NW WASHINGTON DC 20012

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 9, 1966

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: John B. Thomas — Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

25a. REC'D BY REGISTRAR
DATE: AUG 9 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

11534

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11528

Items 13,14 Film G329 8/15/66 mn

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1401 Blair Mill Road.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D C. — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington.
d. STREET ADDRESS: 1445 Ogden Street N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible] Middle Irving Last Dickstein

4. DATE OF DEATH: Month Aug. Day 7 Year 1966

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 26/07

9. AGE (If less than 1 year last birthday) 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PROPRIETOR

10b. KIND OF BUSINESS OR INDUSTRY: Dry Cleaning

11. BIRTHPLACE (State or foreign country): Russia.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Irving Dickstein

14. MOTHER'S MAIDEN NAME: Fay Bogen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Roy Dickstein — Address: 13911 Georgian Drive. Rockville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardio Vascular Disease. — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JOHN G. BALL MD

Address (Street, city, town, or county):

22. DATE SIGNED: 8/7/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/9/66

23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Gard. Cem.

23d. LOCATION (City, town or county) (State): Falls Church, Va.

24. FUNERAL DIRECTOR: Bernard Danzansky & Sons — ADDRESS: 3501-14th St., N.W. Wash. D.C.

25a. REC'D BY REGISTRAR — DATE: AUG 9 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO IDENTIFY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11535

CERTIFICATE OF DEATH

11529

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 6 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10115 Brunett Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eva — Middle: Augusta — Last: Doerr
4. DATE OF DEATH: Month: August — Day: 22 — Year: 1966
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-27-03
9. AGE (In years last birthday): 63 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William H. Phillips
14. MOTHER'S MAIDEN NAME: Mary L Sisk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO: 217-46-8447
17. INFORMANT: Mrs. Carroll Disney — Address: 8120 Lakeside Greenbelt, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Ileus
DUE TO (b): Partial intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 60 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Inoperable recurrent Carcinoma of Sigmoid — 2 years
1523

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 65, 1966, to Aug 21, 1966, that (I) (we) last saw the deceased alive on Aug 21 1966, and that death occurred at 7:05 A M, from causes and on the date stated above.

22a. SIGNATURE: W. W. Eastman — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 22, 1966.
22c. PHYSICIAN'S NAME (Type): W.W. Eastman
22d. ADDRESS: 831 University Blvd. E., Hyattsville Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 24, 1966
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.
24. FUNERAL DIRECTOR: John B. Thomas — Warner E. Pumphrey, Inc. — ADDRESS: 8454 Georgia Ave. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: AUG 24 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11536

CERTIFICATE OF DEATH

11530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the ■ burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 hr 45 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
d. STREET ADDRESS: Kingsview Knolls
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Grace — Middle: Virgil — Last: Dorsey
4. DATE OF DEATH: Month: Aug. — Day: 25 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 11/27/93
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Montgomery - Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Jones
14. MOTHER'S MAIDEN NAME: Miles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Address: 24 West Dean Road Silver Dr. Baltimore 2nd. Anna Mary Magruder - daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4½ hours
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis — Unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 10, 1966, to August 25, 1966, that (I) (we) last saw the deceased alive on August 25 1966, and that death occurred at 3:00 A.M., from causes and on the date stated above.

22a. SIGNATURE: Aaron H. Traum — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: August 25. 1966
22c. PHYSICIAN'S NAME (Type): Aaron H. Traum
22d. ADDRESS: 8237 Georgia Ave Silver Spring Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 28, 1966
23c. NAME OF CEMETERY OR CREMATORY: Neelsville
23d. LOCATION (City or Town) (County) (State): Neelsville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Olin L. Molesworth, Damascus, Md.
25a. REC'D BY REGISTRAR — DATE: AUG 30 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11537

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11531

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5108 Edgemoor Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Joseph — Last: Duffy
4. DATE OF DEATH: Month: 8 — Day: 14 — Year: 1966

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-13-1896
9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months: 7 — Days: 1
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursing Home Retired
10b. KIND OF BUSINESS OR INDUSTRY: Self-employed
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Duffy
14. MOTHER'S MAIDEN NAME: Mary Hadey Fahey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO: 383-07-9500
17. INFORMANT — Address: Niece - Irene Easby-Smith - Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary insufficiency
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial infarction, old
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. S. Murphy M.D
EXAMINER'S NAME (Type): W. S. Murphy, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Rockville, Maryland
22. DATE SIGNED: 14 Aug 66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/17/66
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): P. Georges Co. Maryland

24. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: AUG 17 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

M

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (6)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11538

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11532

1 PLACE OF DEATH
a COUNTY- Montgomery MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,
c LENGTH OF STAY IN 1b D. O. A.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE Maryl. b COUNTY Prince Georges
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel
d STREET ADDRESS Rt. 2, Box 257
e RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Wayne Middle Thomas Last Dustman
4 DATE OF DEATH Month Aug. Day 13 Year 19 66
5 SEX
6 COLOR OR RACE
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH
9 AGE (In years last birthday) 22 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10b KIND OF BUSINESS OR INDUSTRY Maryland University
11 BIRTHPLACE (State or foreign country) Columbus, Ohio
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME Eugene H. Dustman
14 MOTHER'S MAIDEN NAME Jean Walters

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None
16 SOCIAL SECURITY NO 214-42-4868
17 INFORMANT Mr. Eugene H. Dustman Address: Rt. # 2, Box 257 Laurel, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Contusions, Multiple. Myocardium
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Trauma from auto accident.
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH Sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Lost control of car & it turned over.
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8/13 1966
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f (City or town) Wheaton (County) Mont. (State) Md.

21 **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John G. Ball M.D.
EXAMINER'S NAME (Type) John G. Ball
Address (Street, city, town, or county) 7936 Old Georgetown Rd. Bethesda, Maryland

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED 8/13/66

23a BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b DATE THEREOF Aug. 16, 1966
23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery
23d LOCATION (City or Town) (County) (State) Prince Georges Co., Md.

24 FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc.
ADDRESS C. Glen Carter 8434 Georgia Ave. Silver Spring, Md.

25a RECD BY REGISTRAR DATE AUG 16 1966
25b REGISTRAR'S SIGNATURE J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11539

CERTIFICATE OF DEATH

Item #14 infor. taken from birth cert. 8/24/66 pc

11533

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of the death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Md
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Maryland
   d. STREET ADDRESS: 2328 Glenmont Circle #207
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Dwyer

4. DATE OF DEATH: Month: 8 — Day: 19 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/17/66

9. AGE (In years last birthday): ____ yrs. — IF UNDER 1 YEAR: Months ____ Days 2 — IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Montgomery Co, Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William E. Dwyer

14. MOTHER'S MAIDEN NAME: Bronwyn Olyvia Craig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Prematurity

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-17, 1966, to 8-19, 19 66, that (I) (we) last saw the deceased alive on 8-19, 19 66, and that death occurred at 8:19 AM, from the causes and on the date stated above.

22a. SIGNATURE: Frank Mate Jr. — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/19/66

22c. PHYSICIAN'S NAME (Type): Frank Mate, Jr.

22d. ADDRESS: 50 W. Edmondston Drive, Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/20/66

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (City, town or county) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home — ADDRESS: 121 Rockville Pk Rockville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

6-2-1456

10 1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11540 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 11534

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 2 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rockville Motor Hotel

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9901 Markham.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas Middle Oliver Last English.

4. DATE OF DEATH: Month August Day 20 Year 1966

5. SEX: M. 6. COLOR OR RACE: W. 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/2/1898

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Auditor

10b. KIND OF BUSINESS OR INDUSTRY: Avemco

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel- English.

14. MOTHER'S MAIDEN NAME: Nellie (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 340-05-1056

17. INFORMANT: Louise A. English Address: Rockville Motor Hotel Rockville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Corenary Insefficency Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

DUE TO (b): Cardio Vascular Disease. — Years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒; and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 8/21/66

EXAMINER'S NAME (Type): John G. Ball Address (Street, city, town, or county): 7936 Old Georgetown Rd. Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial

23b. DATE THEREOF: Aug. 26, 1966

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town or county) (State): St. Louis, Missouri.

24. FUNERAL DIRECTOR ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME
3500 4-64

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11541

CERTIFICATE OF DEATH

11535

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Congressional Manor Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
b. COUNTY ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: ~~9200 Rockville Pike~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ethelberta Middle Harris Last Featherstone

4. DATE OF DEATH: Month Aug. Day 7 Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 7, 1893

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William E. Harris

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): ~~XX~~ Yes WW I

16. SOCIAL SECURITY NO.: - - -

17. INFORMANT: Robt. H. Featherstone, Address 11404 Stonewood Lane, Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Multiple Myelomata — 1 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this~~ hospital) attended the deceased from 2/57, 19~~66~~, to 8/7, 1966, that (I) (~~we~~) last saw the deceased alive on 8/7 1966, and that death occurred at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE: E. H. Aschenbach — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/7/66

22c. PHYSICIAN'S NAME (Type): E. H. Aschenbach

22d. ADDRESS: 1841 Col. Rd. N.W., DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-10-1966

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem.

23d. LOCATION (City, town or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave. NW, Wash. D.C.

25a. REC'D BY REGISTRAR DATE: AUG 11 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11542

CERTIFICATE OF DEATH

11536

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SANITARIUM HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: MARYLAND
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
d. STREET ADDRESS: 8024 14 AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAX — Middle NMN — Last FEINSTEIN

4. DATE OF DEATH: Month AUGUST — Day 12 — Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-15-93

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: TAILOR

11. BIRTHPLACE (County & State, or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY? AMER.

13. FATHER'S NAME: ALBERT FEINSTEIN

14. MOTHER'S MAIDEN NAME: ? UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO: 213-10-5069

17. INFORMANT: MAX FEINSTEIN — Address: HYATTSVILLE MD 8024 14 AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure. — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Acute Myocardial Infarction — 7 days
DUE TO (c): Coronary Sclerosis
4241
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 15, 1966, to Aug 12, 1966 that (I) (we) last saw the deceased alive on AUG 12 1966, and that death occurred at 10:55 AM, from causes and on the date stated above.

22a. SIGNATURE: Benjamin Isaacson — M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 8/12/66

22c. PHYSICIAN'S NAME (Type): BENJAMIN ISAACSON

22d. ADDRESS: 7733 ALASKA AVE. N.W. WASH. DC.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/15/66

23c. NAME OF CEMETERY OR CREMATORY: Mount Wash. Cem.

23d. LOCATION (City or Town) (County) (State): Hyattsville MD.

24. FUNERAL DIRECTOR: Goldberg Z.H. — ADDRESS: 4217 9th St. N.W.

25a. REC'D BY REGISTRAR DATE: AUG 16 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11543 11537

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: 5 years
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 9302 Compton Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 9302 Compton Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nina — Middle: Marguerite — Last: Ferber

4. DATE OF DEATH: Month: August — Day: 31 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 28, 1899

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Mercersville, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James R. Harper

14. MOTHER'S MAIDEN NAME: Estella Shaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 213-48-0535

17. INFORMANT: Walter Henry Ferber, Jr. — Address: 3105 Fayette Rd. Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Adenocarcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1½ yr.
DUE TO (b): GI Uterus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/14, 1965 to 8/31, 1966, that (I) (we) last saw the deceased alive on 8/15 1966, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Raymond Chinn — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/24/66

22c. PHYSICIAN'S NAME (Type): Raymond Chinn

22d. ADDRESS: 1110 Spring St., S. S., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 3, 1966

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 2 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11544 — 11536

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 6504 4th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: FERRO

4. DATE OF DEATH: Month: August — Day: 13 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8-12-66

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 15 — Min.: 32

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Eugene Ferro

14. MOTHER'S MAIDEN NAME: Antoinette Marie Galipo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mother 6504 4th Avenue, Takoma Park, Maryland
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): APNEA

DUE TO (b): PREMATURITY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ? Respiratory Distress Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 19 ....., to ....., 19 .....; that (I) (we) last saw the deceased alive on ..... 19 ....., and that death occurred at ... M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): MIRKIN, Gabriel, M.D.

22d. ADDRESS: 1110 Spring Street, Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify):

23b. DATE THEREOF: 8/17/66

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (City, town or county) (State): Silver Spring, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Turner-Keelan Funeral Home

ADDRESS: 1371 Rockville Pike, Rockville, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 18 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S 1-66
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11545

CERTIFICATE OF DEATH

11539

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: 2 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: D. C
b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 7
d STREET ADDRESS: 4831 Davenport St NW
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annette — Middle: R. — Last: Fletchall
4 DATE OF DEATH: Month: Aug — Day: 25 — Year: 19 66

5 SEX: Female
6. COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/18/1901
9. AGE (In years last birthday): 65 YRS
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b KIND OF BUSINESS OR INDUSTRY: —
11 BIRTHPLACE (County & State or foreign country): La Crosse, Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Howard H. Rose
14 MOTHER'S MAIDEN NAME: Lillie Butterwalt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No —
16 SOCIAL SECURITY NO: 577-22-1759B
17 INFORMANT: JOHN T. FLETCHALL — Address: 4831 DAVENPORT ST.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 40 hrs
DUE TO (b): Coronary arteriosclerosis — 4 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/24, 1966 to 8/25, 1966 that (I) (we) last saw the deceased alive on 8/25 1966, and that death occurred at 2057 M, from causes and on the date stated above.

22a SIGNATURE: Robert T. Montgomery M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 8/25/66
22c PHYSICIAN'S NAME (Type): ROBERT T. MONTGOMERY
22d. ADDRESS: 5411 CEDAR LANE Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/29/66
23c. NAME OF CEMETERY OR CREMATORY: MONOCACY
23d. LOCATION (City or Town) (County) (State): BEALLSVILLE MD.

24 FUNERAL DIRECTOR: JOS. GAWLER SONS INC.
ADDRESS: 5130 WISC. AVE. NW WASH. D.C.
25a. REC'D BY REGISTRAR DATE: AUG 31 1966
25b REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 13,14 Film 3960 9/1/66 mn

11546

CERTIFICATE OF DEATH

11540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 31 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital,

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7777 Maple Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Clark — Last: FOWLER
4. DATE OF DEATH: Month: August — Day: 24 — Year: 19 66
5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 17 1919
9. AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Marine Corps
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country): Colorado
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 1940-1960
16. SOCIAL SECURITY NO: 712 10 2112
17. INFORMANT: Takoma Park — Address: Maryland
Mrs. Naryne H. Fowler, 7777 Maple Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma lung with metastases — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I)(this hospital) attended the deceased from July 24, 19 66, to August 24 19 66, that (I)(we) last saw the deceased alive on August 24 19 66, and that death occurred at 232A M, from causes and on the date stated above.

22a. SIGNATURE: Perry Ah-Tye — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: August 24, 1966
22c. PHYSICIAN'S NAME (Type): Perry Ah-Tye, M.D.
22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 26 AUGUST 1966
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: Rinaldi Funeral Home — ADDRESS: 7400 Georgia Ave., N.W. Washington, D. C.
25a. RECD BY REGISTRAR DATE: AUG 26 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11547

CERTIFICATE OF DEATH

11541

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: D C — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 4. 3
d. STREET ADDRESS: 3307 Upland Terr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Thomas — Middle A. — Last Fralleone
4. DATE OF DEATH: Month Aug. — Day 6 — Year 1966

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3 October 1914
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fire Ward
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (County & State, or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Julio Fralleone
14. MOTHER'S MAIDEN NAME: Louise Colluzzi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT — Address: Wife Gertrude. — Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): Coronary Artery Desease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. T.S.I
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of the Lung

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Spring, 1963, to Aug 5, 1966, that (I) (~~we~~) last saw the deceased alive on 8/6 1966, and that death occurred at 9 A. M, from causes and on the date stated above.

22a. SIGNATURE: Richard H. Edenbaum M.D. — ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/6/66
22c. PHYSICIAN'S NAME (Type): Richard H. Edenbaum MD
22d. ADDRESS: 4720 Bradley Blvd Ch. Ch. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9 Aug. 1966
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
23d. LOCATION (City or Town) (County) (State): Blaensburg Md.

24. FUNERAL DIRECTOR — ADDRESS: Cinaldi Funeral Home, 1100 Georgia Ave. N.W. DC 20012
25a. RECD BY REGISTRAR DATE: AUG 9 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11543 — 11542

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN this place: 25 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mon[illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 10403 Montrose Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Baby — Middle: Boy — Last: Francis

4. **DATE OF DEATH**: Month: August — Day: 14 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 14, 1966

9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Montgomery Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES LEONARD FRANCIS

14. MOTHER'S MAIDEN NAME: HELEN SUZANNE INGRAHAM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: MOTHER — Address: SAME

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurely
DUE TO (b): Abrupted placenta
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): H/x of habitual abortion -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/14, 1966, to 8/14, 1966, that (I) (we) last saw the deceased alive on 8/14, 1966, and that death occured at 5:45 A M, from the causes and on the date stated above.

22a. SIGNATURE: Edward A Dupell M D — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS

23a. BURIAL (CREMATION) REMOVAL (Specify) — 23b. DATE THEREOF: 8/15/66 — 23c. NAME OF CEMETERY OR CREMATORY: Suburban Hospital — 23d. LOCATION (City, town or county): Bethesda - (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Mrs. Amelia C Carter (EA) — ADDRESS: Administrator

25a. REC'D BY REGISTRAR DATE: AUG 26 1966 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

3430

1 F M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11549 — 11543

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 3½ YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 12228 CEDAR HILL DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LOUISE — Middle: F. — Last: FRANCO

4. DATE OF DEATH: Month: AUGUST — Day: 3 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: OCT 1, 1885

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State or foreign country): PENNA

12. CITIZEN OF WHAT COUNTRY?: U. S. A

13. FATHER'S NAME: NICHOLAS FOLAU

14. MOTHER'S MAIDEN NAME: CATHARINE (UNKNOWN)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 213-48-8760

17. INFORMANT: ROBERT E. DEPEW — Address: 12228 CEDAR HILL DR. SIL. SP. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE
DUE TO
444X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ESSENTIAL HYPERTENSION
DUE TO
(c): GENERALIZED ARTERIOSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JANUARY 11, 1963, to AUG 3, 1966, that (I) (we) last saw the deceased alive on AUG 3 1966, and that death occurred at 2:30 AM, from causes and on the date stated above.

22a. SIGNATURE: Henry M. Lowden M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: AUG 3, 1966

22c. PHYSICIAN'S NAME (Type): HENRY M. LOWDEN

22d. ADDRESS: 5206 Norway Dr Chevy Chase MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/6/1966

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

23d. LOCATION (City or Town) (County) (State): CLARKSBURG, W. VA.

24. FUNERAL DIRECTOR: W. W. CHAMBERS INC. — ADDRESS: SILVER SPRING MD

25a. REC'D BY REGISTRAR DATE: AUG 5 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 film 7380 8/29/66 mh

11550

CERTIFICATE OF DEATH

11544

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fairland Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: West Virginia — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1528 D Lewis St. Charleston
d. STREET ADDRESS: 2516 LOYOLA SOUTHWAY, FAIRLAND, MD
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROSE — Middle: — Last: Friedman

4. DATE OF DEATH: Month: 8 — Day: 14 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday) 84 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MR. MILTON FRIEDMAN, 12 OAK HOLLOW CT. # 9

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Arteriosclerotic heart disease — years
DUE TO
(c):
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1) Hydronephrosis, R. kidney 2) Cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/30, 1966 to 8/14, 1966, that (I) (we) last saw the deceased alive on 8/14 1966, and that death occurred at 8:15 A.M. from causes and on the date stated above.

22a. SIGNATURE: Norman H. Rubenstein — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/14/66

22c. PHYSICIAN'S NAME (Type): NORMAN H. RUBENSTEIN

22d. ADDRESS: WASHINGTON D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/17/66

23c. NAME OF CEMETERY OR CREMATORY: PETACH TIKVAH CONG.

23d. LOCATION (City or Town) (County) (State): BALTIMORE, MARYLAND

24. FUNERAL DIRECTOR — ADDRESS: SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN

25a. REC'D BY REGISTRAR: AUG 16 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11551

11545

1. PLACE OF DEATH a. COUNTY Montgomery County 5025 BROOKDALE ROAD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b 19 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5025 BROOKDALE ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Montgomery Co Md
d. STREET ADDRESS 5025 Brookdale Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First LIDA Middle FULLMAN Last GALLAGHER

4. DATE OF DEATH Month August Day 8 Year 1966

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH April 22 1871
9. AGE (In years last birthday) 75 yrs
IF UNDER 1 YEAR Months 3 Days 16
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Nicholas County West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME THOMAS DRENNAN
14. MOTHER'S MAIDEN NAME KATHERINE RENICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Daughter Address Margaret G. Gallagher 5025 Brookdale Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Arteriosclerosis — 1 hour

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1966 to Aug. 8, 1966, that (I) (we) last saw the deceased alive on Aug. 5 1966, and that death occurred at 8:15 P.M. from the causes and on the date stated above

22a. SIGNATURE Alma Jane Speer M.D. M.D.
ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) ALMA JANE SPEER, M.D.
22d. ADDRESS 3232 GARFIELD ST. N.W. WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF AUG 11 1966
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.
23d. LOCATION (City, town, or county) (State) WHEATON MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE E. Leo Weyl ADDRESS 2222 Wis. Ave. NW Wash. D.C.
25a. REC'D BY REGISTRAR DATE AUG 12 1966
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11552 — 11546

1

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, but in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY ~~Maryland~~ Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney
c. LENGTH OF STAY IN 1b: 57 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy
d. STREET ADDRESS Penn Shop Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Shirley Middle Ann Last Geary

4. DATE OF DEATH: Month 8 Day 28 Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/26/28

9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Picture Developer

10b. KIND OF BUSINESS OR INDUSTRY: Navy Dept.

11. BIRTHPLACE (County & State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clarence H. Geary

14. MOTHER'S MAIDEN NAME: Anna Arnold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Hospital Records, [illegible], Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio. respiratory failure
DUE TO (b) Brain edema
DUE TO (c) Primary Malignant Glioblastoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1731

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/7, 1965, to 8/28, 1966 that (I) (we) last saw the deceased alive on 8/28 1966, and that death occurred at 3:20 P.M., from causes and on the date stated above.

22a. SIGNATURE Louisa S. Batman M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 8-30-66

22c. PHYSICIAN'S NAME (Type) Louisa Batman

22d. ADDRESS Damascus, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF Aug. 31, 1966

23c. NAME OF CEMETERY OR CREMATORY Pine Grove

23d. LOCATION (City or Town) (County) (State) Mt. Airy, Md.

24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.

25a. RECD BY REGISTRAR DATE AUG 31 1966

25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11553 — 11547

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda — c. LENGTH OF STAY IN 1b: 26 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hollywood
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland	d. STREET ADDRESS: Route #1, Box 158 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Edward	Middle: Herman	Last: GIBSON	4. DATE OF DEATH	Month: August	Day: 28	Year: 19 66	
5. SEX: Male	6. COLOR OR RACE: Cauc	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 11 Nov 1918	9. AGE (In years last birthday): 47 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Store Owner	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Mount Holly, South Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Ransom H. Gibson		14. MOTHER'S MAIDEN NAME: Anita Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) Jan-37 to Feb-65	16. SOCIAL SECURITY NO. 250-09-7606	17. INFORMANT: Mrs. Elizabeth Gibson	Address: Route #1, Box 158, Hollywood, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH

5510

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 2 August, 19 66, to 28 August 19 66, that ☒ (we) last saw the deceased alive on 28 August 1966, and that death occurred at 3:00A M, from causes and on the date stated above.

22a. SIGNATURE: D.R. Foreman M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED: 29 August 1966	
22c. PHYSICIAN'S NAME (Type): D.R. Foreman LT MC USN	22d. ADDRESS: U.S. Naval Hospital, Bethesda, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Aug. 31, 1966	23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery	23d. LOCATION (City or Town): Arlington,	(County) (State): Va.
24. FUNERAL DIRECTOR: Mattingley Funeral Home	ADDRESS: Leonardtown, Maryland	25a. RECD BY REGISTRAR DATE: AUG 31 1966	25b. REGISTRAR'S SIGNATURE: Charles Judge	

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11554

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11548

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
   c. LENGTH OF STAY IN 1b: 3 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4604 Sleaford Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
   d. STREET ADDRESS: 4604 Sleaford Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: E. — Last: GILBERT

4. DATE OF DEATH: Month: Aug. — Day: 19, — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 30, 1885

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months: 11 — Days: 19 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Benjamin S. Counselman

14. MOTHER'S MAIDEN NAME: Lena Scherrer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 578-03-9347D

17. INFORMANT: Son — Address: James B. Gilbert — Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardio Vascular Disease — years
DUE TO (c):

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JOHN G. BALL

Address (Street, city, town, or county): Bethesda, Md.

22. DATE SIGNED: Aug. 19, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 8-22-66 — 23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery — 23d. LOCATION (City, town or county) (State): Rockville, Maryland

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REG.STRAR DATE: AUG 24 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME
3500 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (A)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11555

CERTIFICATE OF DEATH

11549

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 13hrs. 47min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 7708 Fortune Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Gilmore

4 DATE OF DEATH: Month: 8 — Day: 21 — Year: 1966

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 8/20/66

9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months: Days: Hours: 13 Min.: 47
IF UNDER 24 HRS.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11 BIRTHPLACE (County & State, or foreign country): Montgomery, Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William F. Gilmore

14. MOTHER'S MAIDEN NAME: Alice Payne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Address: Hospital Records Olney, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Prematurity
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m.: 9:15 8/21/1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/20, 1966, to 8/21, 1966, that (I) (we) last saw the deceased alive on 8/21 1966, and that death occurred at 9:15 AM, from causes and on the date stated above.

22a SIGNATURE: A. D. Bonifant — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-21-66

22c. PHYSICIAN'S NAME (Type): A. D. Bonifant

22d. ADDRESS: Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/23/66

23c. NAME OF CEMETERY OR CREMATORY: Parklawn

23d LOCATION (City or Town) (County) (State): Rockville Maryland

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home

ADDRESS: Rockville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 23 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MET(5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11556 — 11550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 50 mi s
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAMASCUS
d. STREET ADDRESS: 9014 GUE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First LISA — Middle ANNA — Last GORDON

4 DATE OF DEATH: Month AUGUST — Day 19, — Year 19 66

5 SEX: FEMALE — 6 COLOR OR RACE: WHITE — 7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: DEC. 6, 1965

9 AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months 8, Days 13 — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): VIRGINIA

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DONALD F. GORDON

14. MOTHER'S MAIDEN NAME: MARIANNE PETERSON

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO:

17 INFORMANT Address: MOTHER MARIANNE P GORDON SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Laceration & Contusion of Brain —	1/2 hr.
DUE TO (b)	Fracture of skull —	1 1/2 hr.
DUE TO (c)	Trauma from auto accident.	1 1/2 hr.

1220
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Passenger in truck that turned over -

20c. TIME OF INJURY Hour 7:30 p.m. Month, Day, Year 8/19 19 66

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway -

20f (City or town) Damascus (County) Mont. (State) Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspect an ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 8/20/66

23a BURIAL, CREMATION REMOVAL (Specify): Cremation
23b DATE THEREOF: Aug. 22, 1966
23c NAME OF CEMETERY OR CREMATORY: Fort Lincoln
23d. LOCATION (City or Town) (County) (State): Bladensburg, Md.

24 FUNERAL DIRECTOR ADDRESS: Olin L. Molesworth, Damascus, Md.

25a RECEIVED BY REGISTRAR DATE: AUG 23 1966

25b. REGISTRAR'S SIGNATURE: Gloria Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11553 — 11551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Ohio
b. COUNTY: Hamilton
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cincinnati
d. STREET ADDRESS: 625 Orient Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: George — Last: Goshorn
4. DATE OF DEATH: Month: August — Day: 12 — Year: 19 66
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 14 August 1923
9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Proof-Reader
10b. KIND OF BUSINESS OR INDUSTRY: Publishing
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William G. Goshorn
14. MOTHER'S MAIDEN NAME: Christina Wirmel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 285-20-9147
17. INFORMANT: The Medical Record, — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiovascular Failure	30 minutes
410 X		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Myocardial Failure	6 months
DUE TO (c)	Rheumatic Heart Disease with mitral, tricuspid, aortic insufficiency	15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypoxia, respiratory insufficiency, renal failure

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~X~~ (this hospital) attended the deceased from 2 August, 19 66, to 12 August, 19 66, that ☒ (we) last saw the deceased alive on 12 August 19 66, and that death occurred at 5:55 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Sewell H. Dixon, Jr. M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12 August 1966
22c. PHYSICIAN'S NAME (Type): Sewell H. Dixon, Jr., MD
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/15/1966
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town or county) (State): CINCINNATI, OHIO

24. FUNERAL DIRECTOR: Harry E. Hysong — HYSONG'S FUNERAL HOME — ADDRESS: 1300 N. STREET, N.W. WASH. D.C. 20005
25a. REC'D BY REGISTRAR DATE: AUG 15 1966
25b. REGISTRAR'S SIGNATURE: Charles Yeager

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11558

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11552

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
   c. LENGTH OF STAY IN 1b: 2 hr?
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7520 Old Chester Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: MONTGOMERY Co - MARYLAND
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
   d. STREET ADDRESS: 9301 PARKHILL TERRACE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: P — Last: Grant

4. DATE OF DEATH: Month: Aug — Day: 15 — Year: 1966

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 17 1915

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months: 10 Days: 28 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DIRECTOR N.H.I.

10b. KIND OF BUSINESS OR INDUSTRY: N.I.H.

11. BIRTHPLACE (State or foreign country): British Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GARNET P. GRANT

14. MOTHER'S MAIDEN NAME: Olive M'LENNAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 215-38-9823

17. INFORMANT: C.T. SMITH - BROTHER-IN-LAW — Address: LAKE Rd. MORRISTOWN, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Insufficiency Acute. — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Arteriosclerosis — Years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: John G Ball M.D.

EXAMINER'S NAME (Type): JOHN G. BALL

22. DATE SIGNED: 8/16/66

Address (Street, city, town, or county): Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8-19-66

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

23d. LOCATION (City, town or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 19 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5) 5M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11559

CERTIFICATE OF DEATH

11553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 14021 Travilah Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
15-1
d. STREET ADDRESS: 14021 Travilah Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ETHEL Middle M. Last GRIMES

4. DATE OF DEATH: Month Aug. Day 22, Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 8/31/16

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Technician

10b. KIND OF BUSINESS OR INDUSTRY: Electronics

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Harry Gordon

14. MOTHER'S MAIDEN NAME: Hester Doggett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220-26-6564

17. INFORMANT: Mrs Dorothy Beach
Address: 200 N. VanBuren Street Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of left breast with generalized metastases
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1966 to 8/22 1966, that (I) (we) last saw the deceased alive on 8/22 1966, and that death occurred at 11:35 M, from the causes and on the date stated above.

22a. SIGNATURE: Arthur F. Woodward M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/23/66

22c. PHYSICIAN'S NAME (Type): ArthurF.Woodward

22d. ADDRESS: 115 N.VanBuren St., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/25/66

23c. NAME OF CEMETERY OR CREMATORY: Parkla[illegible]

23d. LOCATION (City, town or county) (State): Rockville, Md.

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home
ADDRESS: 1331 Rockville Pike Rockville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 25 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR 415 (4)
20M 1/65

Item 18 Film 380 8-22-66 MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11554

FOR STATE HEALTH DEPT.

11560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c LENGTH OF STAY IN 1b 9 days / 16 hrs. / 30 min
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE Maryland b. COUNTY Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
d STREET ADDRESS 228 Manor Circle
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: William Middle: Joseph Last: Hammond
4 DATE OF DEATH Month: August Day: 14 Year: 19 66
5 SEX Male
6 COLOR OR RACE White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Sep.
8 DATE OF BIRTH 12-3-98
9 AGE (In years last birthday) 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Police
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) Rhode Island Newport
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John P. Hammond
14. MOTHER'S MAIDEN NAME Mary Burke
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI + Navy
16 SOCIAL SECURITY NO. 579-42-4784
17. INFORMANT Chart Address Washington San. Hosp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial heart failure — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.
DUE TO (b) Aspiration of gastric contents — Unknown
DUE TO (c)

1210
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Burns over 35% of body with consequent partial urinary shutdown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.) Found in burning bed of fire with several empty bottles beside and on her
20c TIME OF INJURY Month, Day, Year: Aug 4 1966 Hour: a.m. p.m.
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f (City or town) Silver Spring (County) Montgomery (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE John S. Rogers M.D.
EXAMINER'S NAME (Type) John S. Rogers M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county) 1919 Seminary Rd., Silver Spring, Md.
22. DATE SIGNED 8-14-66

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Aug. 17-1966
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l.
23d LOCATION (City or Town) (County) (State): Arlington, Virginia

24 FUNERAL DIRECTOR: Simmons Bros.
ADDRESS: Simmons Bros.-1661-Good Hope Rd SE Wash DC
25a RECEIVED BY REG STRAR DATE: AUG 16 1966
25b REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11561

CERTIFICATE OF DEATH

11555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Takoma Park md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8101 Eastern Ave. Silver Sp apt 2084 md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Joseph — Middle: Arthur — Last: Handiboe

4. DATE OF DEATH: Month: August — Day: 20 — Year: 1966

5 SEX: Male

6 COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 3-25-81

9. AGE (In years last birthday): 85 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Pressman Bureau of Printing & Engraving

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): Ohio

12 CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: John Handiboe

14 MOTHER'S MAIDEN NAME: Ellen Maguire

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): unknown

16 SOCIAL SECURITY NO.: 577-48-9579

17. INFORMANT: Hospital chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
33.2X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956, 19, to August 20, 1966, that (I) (we) last saw the deceased alive on August 20 1966, and that death occurred at 2:35 P.M., from causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 20, 1966

22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr. M.D.

22d ADDRESS: 9301 Colesville Rd., Silver Spring, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): burial

23b DATE THEREOF: 8/23/66

23c NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d LOCATION (City or Town) (County) (State): Prince Georges County, Md

24. FUNERAL DIRECTOR: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington, D.C.

25a. REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11562 — 11556

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 11 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Holy Cross Hospital

2 USUAL RESIDENCE (Where deceased lived — If institution- Residence before admission)
a. STATE: MD. — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d STREET ADDRESS: 4500 JONES BRIDGE ROAD
e IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: COLEMAN — Middle: Edwin — Last: HANNON

4. DATE OF DEATH: Month: AUGUST — Day: 15 — Year: 1966

5 SEX: MALE

6 COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/19/04

9. AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: C & P Telephone Co.

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13 FATHER'S NAME: E. E. Hannon

14. MOTHER'S MAIDEN NAME: Clara Greenbaum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO: 577-01-2960

17 INFORMANT: Mrs. Lydia Hannon — Address: 4500 Jones Bridge Rd. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA AND HYPERKALEMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) NEPHROSCARCINOSIS — 23 YEARS
DUE TO
(c) PARATHYROID ADENOMA —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PULMONARY EDEMA. PANCREATIC INSUFFICIENCY DUE TO CALCIFICATION
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from JUNE 18, 1953, to AUGUST 15, 1966 that (I) (we) last saw the deceased alive on AUG. 15 1966, and that death occurred at 8:35 P.M. from the causes and on the date stated above.

22a SIGNATURE: James A. Roberts M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: 8/16/66

22c PHYSICIAN'S NAME (Type): JAMES A. ROBERTS

22d ADDRESS: 8907 GEORGIA AVE. SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 18, 1966
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d LOCATION (City town, or county) (State): Rockville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Clark Lewis — ADDRESS: 8434 Georgia Avenue
Clark E. Wisor
Warner E. Pumphrey, Inc. — Silver Spring, Md.

25a REC'D BY REGISTRAR DATE: AUG 19 1966

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11563 — 11557

1 — FOR STATE HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

(I)

1 PLACE OF DEATH — a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: D.O.A.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) — a STATE: Md. — b COUNTY: Mont.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d STREET ADDRESS: 913 Maple Ave.
e RESIDENCE ON A FARM? YES ☐ NO ☒ — 13-1

3 NAME OF DECEASED (Type or print): First NORMAN — Middle L. — Last HARRIS
4 DATE OF DEATH: Month 8 — Day 30 — Year 1966

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8 DATE OF BIRTH: 1-5-1913
9 AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months 7 — Days 25
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b KIND OF BUSINESS OR INDUSTRY: Building
11 BIRTHPLACE (State or foreign country): Montgomery Co. Md.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Joseph Roy Harris
14 MOTHER'S MAIDEN NAME: Helen O'Neale

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: Unknown
17 INFORMANT — Address: Sarah E. Harris - Wife- Same as Item #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary thrombosis
DUE TO (b): due to coronary arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: ϕ Unknown ?

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial infarction, remote

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 8/30/66
Address (Street, city, town, or county): Bethesda, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 9/1/1966
23c NAME OF CEMETERY OR CREMATORY: Potomac Meth. Ch. Cem.
23d LOCATION (City or Town) (County) (State): Potomac Mtg. Co. Maryland

24 FUNERAL DIRECTOR — ADDRESS: Robert A. Pumphrey — Bethesda, Maryland
25a RECORDED BY REGISTRAR — DATE: SEP 6 1966
25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME 6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11564 — 11558

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK MD
c. LENGTH OF STAY IN 1b: 36 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN + HOSP

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE (University Park)
d. STREET ADDRESS: 4204 Sheridan St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SHEPPARD — Middle KNAPP — Last HAYNES

4. DATE OF DEATH: Month 8 — Day 11 — Year 1966

5. SEX: MALE

6. COLOR OR RACE: WH

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/9/88

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DEPT. of Agriculture
10b. KIND OF BUSINESS OR INDUSTRY: (RETIRED)

11. BIRTHPLACE (County & State, or foreign country): Connecticutt

12. CITIZEN OF WHAT COUNTRY? Amer

13. FATHER'S NAME: Alfred Haynes

14. MOTHER'S MAIDEN NAME: Louise Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 217-52-6727

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cer. Embolism left - — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO (b): - Bronchopneumonia — 3 days
DUE TO (c): Cerebral Hemorrhage - — 36
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chr Dig Myocarditis - 6 yrs!

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/28/65, 19 to 8/11, 1966, that (I) (we) last saw the deceased alive on 8/14/1966, and that death occurred at 9 AM, from causes and on the date stated above.

22a. SIGNATURE: Howard Horse M D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/11/66

22c. PHYSICIAN'S NAME (Type): Howard T Horse MD

22d. ADDRESS: 7030 Carroll Ave Takoma Park Md 20

23a. BURIAL, CREMATION, REMOVAL (Specify): (Burial)

23b. DATE THEREOF: Aug. 15, 1966

23c. NAME OF CEMETERY OR CREMATORY: The Stone Church

23d. LOCATION (City or Town) (County) (State): East Lyme New London, Conn

24. FUNERAL DIRECTOR: F. Sasscer Sons

ADDRESS: Hyattsville, Md.

25a. RECD BY REGISTRAR DATE: AUG 16 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11565 — **CERTIFICATE OF DEATH** — 11559

Item #3, 1966 Amd. 7/11/66mab

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington Grove
d. STREET ADDRESS: 406-5th. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY H Clark — Middle H — Last CLARK Helms

4. DATE OF DEATH: Month 8-8-66 — Day — Year 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-5-1890

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Security Salesman

10b. KIND OF BUSINESS OR INDUSTRY: N.Y. Stock Exc.

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. Helms

14. MOTHER'S MAIDEN NAME: Elizabeth Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 578-01-0607

17. INFORMANT: Hospital Admission Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Atherosclerosis, severe Aorta, — INTERVAL BETWEEN ONSET AND DEATH: 4 years,
DUE TO (b): Coronaries + Gen'l- — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Myocardial Scarring - Post. L.V. Wall + Septum

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Prostate

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7-25, 66, to 8-8, 66, that (I) (~~we~~) last saw the deceased alive on 8-8 1966, and that death occurred at 9:30AM, from causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-8-66

22c. PHYSICIAN'S NAME (Type): Jack Schumacher, M. D.

22d. ADDRESS: Gaithersburg, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8-11-66

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): Bladensburg, Md.

24. FUNERAL DIRECTOR: Ernest C. Gartner — ADDRESS: Ernest C. Gartner, Gaithersburg, Md.

25a. REC'D BY REGISTRAR DATE: AUG 11 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 10
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11565 — 11560

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form HM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 1 hour 10 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville
d. STREET ADDRESS: 1001 Chillum Road Apt 316
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: BARNEY — Middle: (NONE) — Last: HERMAN

4 DATE OF DEATH: August 7 1966

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 12-3-85

9 AGE (In years / last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (Glazier)

10b KIND OF BUSINESS OR INDUSTRY: GLASS

11 BIRTHPLACE (State or foreign country): Russia

12 CITIZEN OF WHAT COUNTRY?: Amer.

13 FATHER'S NAME: Herman (cuck)

14 MOTHER'S MAIDEN NAME: ? (cuck)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —

16 SOCIAL SECURITY NO.: 10-09-4098

17. INFORMANT: Chart — Address: Hosp.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Insufficiency Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Cardio Vascular Disease — years.
DUE TO
(c):

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour o'm. a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John D. Bell M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 8/7/66

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 8/8/66
23c NAME OF CEMETERY OR CREMATORY: Geo. Wash. Mem. Pk.
23d LOCATION (City or Town) (County) (State): HYATTSVILLE MD

24 FUNERAL DIRECTOR: Bradley Funeral Home
ADDRESS: 4217-9th Nw

25a RECD BY REGISTRAR DATE: AUG 9 1966
25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11567 — 11561

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 928 Wayne
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clyde — Middle: Rowe — Last: Herman

4. DATE OF DEATH: Month: August — Day: 5 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-28-11

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Mfg Development Corp

11. BIRTHPLACE (County & State, or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John B. Herman

14. MOTHER'S MAIDEN NAME: Gertrude Rowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 168-16-2074

17. INFORMANT: Florence Herman — Address: 938 Wayne Ave., S.S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Aspiration / Gastric Contents — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Status post Craniotomy — 1 wk
DUE TO (c): Glio Blastoma Multiforme — 6 + mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-22, 1966 to 8-5, 1966 that (I) (we) last saw the deceased alive on 8-5, 1966 and that death occurred at 12:20 P.M. from causes and on the date stated above.

22a. SIGNATURE: Jonathan M. Williams — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-5-66

22c. PHYSICIAN'S NAME (Type): Jonathan M. Williams

22d. ADDRESS: 808 Pershing Dr. Silv. Spg. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/9/66

23c. NAME OF CEMETERY OR CREMATORY: George Washington

23d. LOCATION (City or Town) (County) (State): Adelphi, Maryland

24. FUNERAL DIRECTOR: John B. Thomas — John B. Thomas — ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Ave., S.S. Md.

25a. REC'D BY REGISTRAR DATE: AUG 9 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11562 11562

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda(rural)
c. LENGTH OF STAY IN 1b: 11 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S.Naval Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Florida — b. COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Milton (rural)
d STREET ADDRESS: Route 5,Box 387
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: David — Middle: Sheldon — Last: Hibbitts
4. DATE OF DEATH: Month: August — Day: 3 — Year: 1966

5 SEX: Male
6 COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 23 Jun 1966
9 AGE (In years last birthday): ----- yrs
IF UNDER 1 YEAR: Months 1 Days 11 — IF UNDER 24 HRS.: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11 BIRTHPLACE (County & State, or foreign country): Milton, Florida
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James W Hibbitts
14 MOTHER'S MAIDEN NAME: Ruth Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: N/A
17. INFORMANT: Milton — Address: Florida
Mr. James W. Hibbitts, Route 5, Box 387/

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cyanotic congenital heart disease — INTERVAL BETWEEN ONSET AND DEATH
1070
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (☒ this hospital) attended the deceased from July 24, 1966, to Aug. 3, 1966 that (☒ we) last saw the deceased alive on Aug. 3 1966, and that death occurred at 705P M, from causes and on the date stated above.

22a. SIGNATURE: Ronald F. Swanger M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: Aug. 4, 1966
22c. PHYSICIAN'S NAME (Type): Ronald F. Swanger, M. D.
22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-8-66
23c. NAME OF CEMETERY OR CREMATORY: Knob Lick Cemetery
23d. LOCATION (City or Town) (County) (State): Knob Lick, Missouri

24. FUNERAL DIRECTOR: R. A. Pumphrey — ADDRESS: 7557 Wisconsin Ave., Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 8 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11569 — Reg. Dist. No. 11563

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5104 Danbury Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5104 Danbury Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mabel — Middle: Marie — Last: Hirschman
4. DATE OF DEATH: Month: Aug. — Day: 4 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-3-1891
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Archibald C. Columbus
14. MOTHER'S MAIDEN NAME: Laura Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: 213-56-1873
17. INFORMANT — Address: George F. Hirschman- See Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO (b): Generalized arteriosclerosis — 5 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid arthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. ft. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1962, to Aug. 4, 1966, that I last saw the deceased alive on Aug. 4, 1966, and that death occurred at 12:20 M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hartman M.D. — ADDRESS (Street, city or town, state): 2001 Eye N. W. Washington, D.C. — DATE SIGNED: 8/7/66

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-6-1966
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wise. Ave. N.W. Wash. D.C.
24a. REC'D BY REGISTRAR DATE: AUG 8
24b REGISTRAR'S SIGNATURE: 966 [illegible] Hartley Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11570 — 11564

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. Gaithersburg
c. LENGTH OF STAY IN 1b: Years.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 2 Box 316.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg (Rural)
d. STREET ADDRESS: Route #2 - Box 316.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Kermit — Middle: R. — Last: Howard
4. DATE OF DEATH: Month: August — Day: 19 — Year: 19 66

5. SEX: M.
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 18 1901
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Co. Road Dept.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John. A. Howard.
14. MOTHER'S MAIDEN NAME: Cora. S. Royer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-14-7156
17. INFORMANT — Address: Mrs Artie B. Howard, Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 42.1
DUE TO (b): Cardio Vascular Disease — 4 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 8/20/66
EXAMINER'S NAME (Type): John G. Ball
Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 22, 1966
23c. NAME OF CEMETERY OR CREMATORY: Seals Cemetery
23d. LOCATION (City, town or county) (State): Nr. Etchison, Md.

24. FUNERAL DIRECTOR — ADDRESS: Olin L. Molesworth, Damascus, Md.
25a. REC'D BY REGISTRAR DATE: AUG 23 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11571 — Item #y Film #G380 8/2/66 PS — 11565

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: Rt # 3 Turkey Foot Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Boy — Middle: A (Twin) — Last: Jackson

4. DATE OF DEATH: Month: Aug — Day: 15 — Year: 1966

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8-15-66

9. AGE (In years last birthday): 0 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours: 10 / Min.: 4

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: George F. Jackson

14. MOTHER'S MAIDEN NAME: Ethel H. Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Atelaectasis
DUE TO (b): Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19 — **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ — **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... 19 , to ..... 19 ..... , that (I) (we) last saw the deceased alive on Aug 15 19 66, and that death occured at 11:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert O. Wenker M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8.16.66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: 3716 Howard Ave, Kensington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/17/66

23c. NAME OF CEMETERY OR CREMATORY: Seneca Cemetery

23d. LOCATION (City, town or county) (State): Seneca, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 18 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 [illegible] retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11572 — 11566

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: RT #3 Turkey Foot Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First — Last: JACKSON — Middle: GIRL-TW.N-B.

4. DATE OF DEATH: Month: 8 — Day: 15 — Year: 1966

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8-15-66

9. AGE (In years last birthday): 0 yrs — IF UNDER 1 YEAR: Months: 0, Days: 0 — IF UNDER 24 HRS: Hours: 8, Min.: 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: George F. Jackson

14. MOTHER'S MAIDEN NAME: Ethel H. Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PULMONARY ATELECTASIS

DUE TO (b): PREMATURITY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19....., that (I) (we) last saw the deceased alive on 8-15 1966, and that death occured at 9:52 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert O. Warthen M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8-15-66

22c. PHYSICIAN'S NAME (Type): / — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 8/17/66 — 23c. NAME OF CEMETERY OR CREMATORY: Seneca Cemetery — 23d. LOCATION (City, town or county) (State): Seneca, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md. — 25a. REC'D BY REGISTRAR: AUG 18 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11573 — 11567

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head
d. STREET ADDRESS: 16 Cypress Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Gordon — Last: Jansen

4. DATE OF DEATH: Month: August — Day: 10, — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 December 1958

9. AGE (In years last birthday): 7 yrs.
IF UNDER 1 YEAR — Months: — Days: —
IF UNDER 24 HRS. — Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas R. Jansen

14. MOTHER'S MAIDEN NAME: Rose Payne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Interstitial pneumonia - etiology unknown — INTERVAL BETWEEN ONSET AND DEATH: 10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Lymphosarcoma with leukemia — 2½ years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from August 4, 19 66, to August 10 19 66, that ☒ (we) last saw the deceased alive on August 10, 19 66, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: William R. Levis — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: August 10, 1966

22c. PHYSICIAN'S NAME (Type): William R. Levis, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8-12-66

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON CEM.

23d. LOCATION (City, town or county) (State): ARLINGTON VA.

24. FUNERAL DIRECTOR: The Huntt Funeral Home

ADDRESS: Waldorf, Md

25a. REC'D BY REGISTRAR DATE: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: Charles [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11573 WT. 1-10

CERTIFICATE OF DEATH

Items 13,14 Information from birth cert.

11568

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital
d. STREET ADDRESS: 5051 Bradley Blvd Apt #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gail — Middle: Jean — Last: Jenkins

4. DATE OF DEATH: Month: Aug — Day: 26 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 26, 1966
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 2 Min: 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Mont. Co, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Edward Jenkins
14. MOTHER'S MAIDEN NAME: Doris Ann Vogel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure
DUE TO (b): Prematurity
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 7735

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-26, 19 66, to 8-26, 19 66, that (I) (we) last saw the deceased alive on 8-27 19 66, and that death occurred at 6:35 AM, from causes and on the date stated above

22a. SIGNATURE: Thomas J Truendle M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 8/29/66
23c. NAME OF CEMETERY OR CREMATORY: Suburban Hospital
23d. LOCATION (City or Town) (County) (State): Bethesda-Monty. MD

24. FUNERAL DIRECTOR: Mrs. Amelia C Carter, Administratrix (EN)
ADDRESS: " "
25a. REC'D BY REGISTRAR DATE: AUG 30 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11575 — 11569

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 3 Mos. 1 Da.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 6709 Melville Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: NETTIE — Middle: P. — Last: JOHNSON

4. DATE OF DEATH: Month: AUGUST — Day: 1 — Year: 1966

5 SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 18, 1878

9 AGE (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months: 0 — Days: 13

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): New York

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Nathan J. Putnam

14. MOTHER'S MAIDEN NAME: Sarah J. Terrell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 213-48-0840

17. INFORMANT: Daughter — Address: Same as Item 2. — Mrs. Thomas B. Jacocks

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE
4447
DUE TO
(b): ESSENTIAL HYPERTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): GENERALIZED ARTERIOSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SENILITY

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from APRIL 20, 1966 to AUG 1, 1966, that (I) (~~we~~) last saw the deceased alive on AUG. 1 1966, and that death occurred at 1:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/1/66

22c. PHYSICIAN'S NAME (Type): HENRY M. LOWDEN

22d. ADDRESS: 5206 Norwood Dr. Chevy Chase Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 8-3-66

23c NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR: Robert A Pumphrey — ADDRESS: Bethesda, Maryland

25a REC'D BY REGISTRAR DATE: AUG 3 1966

25b REGISTRAR'S SIGNATURE: [signature]

1 M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11576 **CERTIFICATE OF DEATH** 11576

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Page 3 should be detached for use as the burial-transit permit. Then, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 4 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: E — Last: Jones

4. DATE OF DEATH: Month: Aug. — Day: 28 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: June 12, 1871

9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington D.C

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Clay Sherman

14. MOTHER'S MAIDEN NAME: Susan McConnel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 220 44 1572

17. INFORMANT: Mrs Elgar S. Gilmore — Address: 8117 Rayburn Pl Bethesda Md. 20034

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): A.S.H.D. — INTERVAL BETWEEN ONSET AND DEATH: 5 years
4210
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): generalized A.S.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 6-1, 1966 to 8-28, 1966, that (I) (we) last saw the deceased alive on 8-28 1966, and that death occurred at 9:2 P M, from causes and on the date stated above.

22a. SIGNATURE: G. F. Sengstack M.D.
M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-28-66

22c. PHYSICIAN'S NAME (Type): George F. Sengstack

22d. ADDRESS: 9211 Columbia Blvd. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 1 1966

23c. NAME OF CEMETERY OR CREMATORY: Friends

23d. LOCATION (City or Town) (County) (State): Sandy Spring Mont. Md.

24. FUNERAL DIRECTOR: Francis H. Barber — Francis H. Barber
ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 30 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11577 **CERTIFICATE OF DEATH** 11571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: MONTGOMERY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
   d. STREET ADDRESS: 8510 16th St
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle — Last KANTOR

4. DATE OF DEATH: Month AUG. — Day 18 — Year 19 66

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-13-09

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANAGER

10b. KIND OF BUSINESS OR INDUSTRY: LADIES WEAR

11. BIRTHPLACE (County & State, or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LAZAR KANTOR

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WWII — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 062-07-5191

17. INFORMANT: MRS. NELSON - BRONX — Address: Bronxville N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CEREBRAL THROMBOSIS	20 DAYS
DUE TO (b)	CEREBRAL ARTERIO SCLEROSIS	18 MONTHS
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CORONARY ARTERY DISEASE CONGESTIVE HEART FAILURE; BRONCHO PNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from FEB, 19 65 to 8/18, 19 66, that (I) (~~was~~) last saw the deceased alive on 8/17 19 66, and that death occurred at 5:50 A M, from causes and on the date stated above.

22a. SIGNATURE: David Goldenberg — M.D — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 8/18/66

22c. PHYSICIAN'S NAME (Type): DAVID GOLDENBERG

22d. ADDRESS: 10620 Georgia Ave Silver Spring Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/19/66

23c. NAME OF CEMETERY OR CREMATORY: RIVERSIDE CEMETERY

23d. LOCATION (City or Town) (County) (State): ROCHELLE PARK N.J.

24. FUNERAL DIRECTOR: Goldberg Funeral Home — ADDRESS: 4217 9th St. N.W.

25a. REC'D BY REGISTRAR DATE: AUG 22 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11578 — 11572

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK, Md. c. LENGTH OF STAY IN 1b: 2 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PK., ~~Md.~~
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH. Sanitarium & Hospital	d. STREET ADDRESS: 6708 Cockerille Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
ELLA	LORETTA	KEARNS	AUG.	3	19 66

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Caucasian		11 ~~XX~~-7-75	90 ~~XX~~ yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Wheeling, W. Va, ~~Ohio~~	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DENNIS DENT	ELLEN COSTELLO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No — None	219-54-7863T	Veronica ~~Boyd~~ Baxter, Daughter	ISLAND HOUSE KEY BISCAYNE, FLA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Cardiomegaly
DUE TO (c): Pleural effusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 weeks

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paralytic ileus, Urinary Tract Infection, Hematuria, Annular Fibrillation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-13, 1966, to 8-3, 1966, that (I) (we) last saw the deceased alive on 8-3 1966, and that death occurred at 9:00 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Alan R. Gair					8-3-66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
ALan R. Gair MD	7777 Maple Ave, Takoma Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Aug. 6, 1966	Fort Lincoln Cemetery	Prince Georges Co., Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. Glen Carter Glen Carter Warner E. Pumphrey, Inc.	8434 Georgia Ave. Silver Spring, Md.	AUG 8 1966	J. Charles Judge

Items 18&21 Film 380 8

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11579

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11573

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 25 hrs/25 mi
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium Hospital
d. STREET ADDRESS: 8103 Garland Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

8. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: Leo — Last: Kelley

4. DATE OF DEATH: Month: August — Day: 14 — Year: 1966

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-24-1898 — 9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Metro. Police Dept.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Kelley

14. MOTHER'S MAIDEN NAME: Nora Broderick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 553-22-1156

17. INFORMANT: Chart — Address: 7400 Carroll Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial & coronary heart failure — INTERVAL BETWEEN ONSET AND DEATH: ½ hr.

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute hemorrhagic pancreatitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒ ///

ACTUAL SIGNATURE OF EXAMINER: John S. Rogers M.D.
EXAMINER'S NAME (Type): John S. Rogers M.D.
1919 Seminary Rd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town or county): Silver Spring Md

22. DATE SIGNED: 8-15-66

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 18 Aug. 1966
23c. NAME OF CEMETERY OR CREMATORY: St. Johns Church Cemetery
23d. LOCATION (City, town or county) (State): Silver Spring Md.

24. FUNERAL DIRECTOR: Rinaldi Funeral Home
ADDRESS: 7400 Georgia Ave. N.W. Dc 20012
25a. REC'D BY REGISTRAR DATE: AUG 17 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11580 — 11574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington — c. LENGTH OF STAY IN 1b: 2 Weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Nursing Home	d. STREET ADDRESS: 7508 Old Chester Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLA — Middle G. — Last KING	4. DATE OF DEATH: Month Aug. — Day 7, — Year 1966							
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Nov. 14, 1879	9. AGE (In years last birthday): 86 yrs	IF UNDER 1 YEAR: Months 8	Days 23	IF UNDER 24 HRS: Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Canada	12. CITIZEN OF WHAT COUNTRY? U. S.					
13. FATHER'S NAME: Milo Brooks	14. MOTHER'S MAIDEN NAME: Elizabeth Merrill							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 232-22-1304D	17. INFORMANT: Mrs. Harriet Godfrey — Address: Same as Item 2.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	10 minutes
DUE TO (b)	Arteriosclerotic Cardiovascular Disease	—
DUE TO (c)	Diabetes Mellitus	35 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arteriosclerosis obliterans

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August, 1964, to Aug. 7, 1966 that (I) (we) last saw the deceased alive on July 19 19 66 and that death occurred at 7:04 A.M. from causes and on the date stated above.

22a. SIGNATURE: Edward W. Youngblood M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 8-7-66		
22c. PHYSICIAN'S NAME (Type): EDWARD W. YOUNGBLOOD	22d. ADDRESS: 8606 Ewing Dr., Bethesda, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE THEREOF: 8-8-66	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State): Suitland, Maryland
24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY	ADDRESS: Bethesda, Maryland	25a. REC'D BY REGISTRAR DATE AUG 3 1966	25b. REGISTRAR'S SIGNATURE: Charles Jr.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11581 — 11575

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK,
d. STREET ADDRESS: 708 DEVONSHIRE RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First WALTER — Middle Moran — Last KIRKLEY

4. **DATE OF DEATH**: Month AUGUST — Day 6 — Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 7/XX/06

9. AGE (In years last birthday): 60 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor

10b. KIND OF BUSINESS OR INDUSTRY: Officers Club

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles William Kirkley

14. MOTHER'S MAIDEN NAME: Anna Bellew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None

16. SOCIAL SECURITY NO: 578-09-5554

17. **INFORMANT**: Elaine R. Kirkley — Address: 708 Devonshire Rd. Takoma Park, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: hours.
I 201
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Coronary athero. heart disease — 13 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema, Kidney Disease, Cirrhosis of the liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/5/66, 19__, to 8/6/66, 19__, that (I) (we) last saw the deceased alive on 8/6/66 19__, and that death occurred at 1:55 P.M., from causes and on the date stated above.

22a. SIGNATURE: Bernard J. Walsh, M.D — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 8/7/66

22c. PHYSICIAN'S NAME (Type): Bernard J. Walsh

22d. ADDRESS: 1800 Eye St. N.W. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 10, 1966

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

23d. LOCATION (City or Town) (County) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR: C. Glen Carter, Warner E. Pumphrey, Inc. — ADDRESS: C. Glen Carter 8434 Georgia Ave. Silver Spring, Md.

25a. RECD BY REGISTRAR DATE: AUG 9 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11582

CERTIFICATE OF DEATH

11576

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 12 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1919 Lucas Grove Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sidney — Middle: Allen — Last: Koch

4. DATE OF DEATH: Month: August — Day: 23 — Year: 19 66

5. SEX: M

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-1-34

9. AGE (In years last birthday): 31 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physicist

10b. KIND OF BUSINESS OR INDUSTRY: Hemoglobin Lab

11. BIRTHPLACE (County & State or foreign country): Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Chris Koch

14. MOTHER'S MAIDEN NAME: Lydia (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Teddy W. Roe — Address: 4401 N. Early St. Rosslyn Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intraventricular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12hrs
DUE TO (b): Rupture, L. Posterior Communic. Art. Aneurysm — 12hrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
30X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-23, 1966, to 8-23, 1966, that (I) (we) last saw the deceased alive on 8-23, 1966, and that death occurred at 11:50 AM, from causes and on the date stated above.

22a. SIGNATURE: Jonathan M. Williams M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 8-23-66

22c. PHYSICIAN'S NAME (Type): Jonathan M. Williams MD

22d. ADDRESS: 808 Pershing Dr. Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8/24/66

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City or Town) (County) (State): Colmar Manor Prince Geo. Md

24. FUNERAL DIRECTOR: W. W. Chambers Co., Silver Spring Md

ADDRESS

25a. REC'D BY REGISTRAR DATE: AUG 29 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

4

1

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11583

11577

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b: —

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: D.C. — b COUNTY: ✓
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 311 - GALLATIN ST-NW
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RANDOLPH HILLS NURSING HOME

3. NAME OF DECEASED (Type or print): First SARA — Middle — Last KURLAND

4. DATE OF DEATH: Month AUGUST — Day 6 — Year 1966

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 1884
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL BARROW
14. MOTHER'S MAIDEN NAME: FAYGA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes give war or dates of service) —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: JACOB KURLAND — Address: (See 1a above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	INTESTINAL HEMORRHAGE	24 HOURS
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	METASTATIC CARCINOMA	OVER 3 MOS.
DUE TO (c)	CARCINOMA of COLON, POST-OPERATIVE	4½ YEARS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HYPERTENSIVE CARDIO-VASCULAR DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NO
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 10 APRIL, 1966, to 6 August, 1966, that (I) (~~we~~) last saw the deceased alive on 6 AUGUST 1966, and that death occurred at 9.30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Israel Kessler — M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 8-6-66
22c. PHYSICIAN'S NAME (Type): ISRAEL KESSLER, M.D
22d. ADDRESS: 5801-16th St. N.W., WASH. D.C.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 8/8/1966
23c NAME OF CEMETERY OR CREMATORY: NAT'L. MEM. PARK
23d LOCATION (City or town) (County) (State): FALLS CHURCH. VA.

24. FUNERAL DIRECTOR: Stedberg Funeral Home — ADDRESS: 4217 4th St. N.W.

25a. RECD BY REGISTRAR DATE: AUG 9 1966
25b REGISTRAR'S SIGNATURE: by Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11584 — 11578

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 136 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Oregon — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Junction City
d. STREET ADDRESS: 5366 River Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Guy — Middle: Vivian — Last: Lamoreaux

4. DATE OF DEATH: Month: August — Day: 5 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 6 July 1887

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Archibald O. Lamoreaux

14. MOTHER'S MAIDEN NAME: Lydia Crockett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 541-18-3511

17. INFORMANT: The Medical Record, — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Mycosis Fungoides — INTERVAL BETWEEN ONSET AND DEATH: 25 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from 22 March, 1966, to 5 August, 1966, that (we) last saw the deceased alive on 5 August, 1966, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Myron J. Levin M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 5 August 1966

22c. PHYSICIAN'S NAME (Type): Myron J. Levin, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8-10-66

23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.

23d. LOCATION (City, town or county) (State): EUGENE, OREGON

24. FUNERAL DIRECTOR: JOSEPH GAWLER'S SONS, INC. — ADDRESS: WASHINGTON, D.C.

25a. REC'D BY REGISTRAR DATE: AUG 11 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11585

CERTIFICATE OF DEATH

Reg. Dist. No. 14579

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Maryl nder Home of Last

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kifer, Maryland
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emily — Middle B. — Last Lancaster
4. DATE OF DEATH: Month Aug. — Day 26 — Year 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 7, 1883
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months 7 — Days 19 — IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Loartown, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Holland Bane
14. MOTHER'S MAIDEN NAME: Rebecca Loar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
INFORMANT: Evelyn Crabtree — Address 4216 Brookfield Dr.
Mrs. Evelyn Crabtree, Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 17 years
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/23, 19 65 to 8/26, 1966 that I last saw the deceased alive on 8/24, 19 66, and that death occurred at 3:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Kerr M.D
ADDRESS (Street, city or town, state): 26618 Ridge Rd. Damascus, Md.
DATE SIGNED: 3/27/66
PHYSICIAN'S NAME (Type): James P. Kerr, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 8/2[illegible]/66
22c. NAME OF CEMETERY OR CREMATORY: Sulphur Springs Cem.
22d. LOCATION (City, town, or county) (State): Kifer, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Kensan Funeral Home — ADDRESS: Berkeley Springs, W. Va.
24a. REC'D BY REGISTRAR DATE: SEP 6 1966
24b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11586 11580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 18 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 3300 Jones Bridge Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 3300 Jones Bridge Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katheryne — Middle: Thom — Last: La Place

4. DATE OF DEATH: Month: August — Day: 19 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 9, 1884

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Thom

14. MOTHER'S MAIDEN NAME: Catherine Cooksey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: yes

17. INFORMANT: Mrs. Katheryne Burke — Address: 3302 Jones Bridge Rd. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): massive myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
1228
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): carcinomatosis; primary lesion colon — 2 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959, 19, to 19 Aug, 19 66 that (I) (we) last saw the deceased alive on 17 Aug 19 66, and that death occurred at 11:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John M. Wyman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 19 Aug. 1966

22c. PHYSICIAN'S NAME (Type): John M. Wyman, M.D.

22d. ADDRESS: 7801 Norfolk Avenue Bethesda, Maryland 20014

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 22, 1966

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION (City, town or county) (State): Prince Georges Co., Md.

24. FUNERAL DIRECTOR: C. Glen Carter — Warner E. Pumphrey, Inc.
ADDRESS: C. Glen Carter 8434 Georgia Ave. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11587 — 11581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 414 Silver Spring Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Lee — Last: Lechlider SR

4. DATE OF DEATH: Month: August — Day: 25 — Year: 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-17-86

9. AGE (In years last birthday): 80 yrs
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Bldg. Construction

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles E Lechlider

14. MOTHER'S MAIDEN NAME: Amelia Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
    (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 577-26-8417

17. INFORMANT: Mrs. William Wright — Address: 15 Greenway Pl., Greenbelt, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY
    IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
    DUE TO (b): ASCVD
    DUE TO (c):
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 420.1

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial Infarction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-8, 1966 to 8-25, 1966 that (I) (we) last saw the deceased alive on 8-25 1966 and that death occurred at 1:50 P.M. from causes and on the date stated above.

22a. SIGNATURE: A.W. Danish M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8-24-66

22c. PHYSICIAN'S NAME (Type): A.W. DANISH, M.D.

22d. ADDRESS: 1166 Spring St., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 27, 1966

23c. NAME OF CEMETERY OR CREMATORY: Burtonsville Union Cemetery

23d. LOCATION (City or Town) (County) (State): Burtonsville, Maryland

24. FUNERAL DIRECTOR: John B. Thomas, John B. Kline, 8434 Georgia Ave.
    Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR: DATE AUG 29 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Yingling

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11583 — 11582

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
   c. LENGTH OF STAY IN 1b: 16 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: West Virginia
   b. COUNTY: Greenbrier
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton ville
   d. STREET ADDRESS: No street address
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leslie — Middle: Grant — Last: Legg

4. DATE OF DEATH: Month: August — Day: 25 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 July 1899

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Legg

14. MOTHER'S MAIDEN NAME: Ida Hartsook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 236-05-8562

17. INFORMANT: The Medical Records, (Nita E. Legg-) — ADDRESS: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 14 Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral hemorrhage ? — 2 Days
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 9 August, 19 66, to 25 August, 19 66, that ☒ (we) last saw the deceased alive on 25 August 19 66, and that death occurred at 11:35 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Dr. Charles L. Vogel — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 26 August 1966

22c. PHYSICIAN'S NAME (Type): Charles L. Vogel, MD.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/29/1966

23c. NAME OF CEMETERY OR CREMATORY: Rosewood Cemetery

23d. LOCATION (City, town or county) (State): Clintonville, West, Va.

24. FUNERAL DIRECTOR: C. Glen Carter Glen Carl 8434 — ADDRESS: Ga. Ave.
Warner E. Pumphrey, Inc Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: AUG 31 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11589 — Item 9 filed 8/31/66 mh — 11583

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 189 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Maryland

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New York
b. COUNTY: Albany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Albany
d. STREET ADDRESS: 14 Pauline Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marilyn — Middle: Jeanne — Last: Leonardi

4. DATE OF DEATH: Month: August — Day: 21 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 28 June 1929

9. AGE (In years last birthday): 37 36 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edmund Burhans

14. MOTHER'S MAIDEN NAME: Aileen Kramer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 083-22-5385

17. INFORMANT: The Medical Records, Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 Hours

1450

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Adrenal Carcinoma (Widespread) — 3 Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 13 February, 19 66, to 21 August, 19 66, that ☒ (we) last saw the deceased alive on 21 August 19 66, and that death occurred at 7:48 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Mortimer B. Lipsett — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 22 August 1966

22c. PHYSICIAN'S NAME (Type): Mortimer B. Lipsett, MD.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/25/66

23c. NAME OF CEMETERY OR CREMATORY: St. Agnes

23d. LOCATION (City, town or county) (State): Colonie, New York

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home — ADDRESS: 1331 Rockville Pike, Rockville, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 25 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11590

CERTIFICATE OF DEATH

11584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 13109 Tamarack Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BENNIE — Middle — Last LIPSEY

4. DATE OF DEATH: Month August — Day 22 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 15, 1902

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Morris Lupschutz

14. MOTHER'S MAIDEN NAME: Ida Trupp

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --------

16. SOCIAL SECURITY NO.: 577-18-8453

17. INFORMANT — Address: Mrs. Bessie Kramer, Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO (b): Carcinoma Lung
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov, 19 65, to aug 22, 19 66, that (I) (we) last saw the deceased alive on Aug 22 19 66, and that death occurred at 9:30 A M, from causes and on the date stated above.

22a. SIGNATURE: Robert Kramer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 23, 1966

22c. PHYSICIAN'S NAME (Type): ROBERT KRAMER, M.D.

22d. ADDRESS: 8484 16th Street, Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug, 24, 1966

23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park

23d. LOCATION (City or Town) (County) (State): Falls Church — Virginia

24. FUNERAL DIRECTOR — ADDRESS: Goldberg Fueral Home — 4217 9th St., N.W.

25a. REC'D BY REGISTRAR DATE: AUG 26 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11591 — 11585

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CORONER Notified and Approved WDB

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Echo Heights
c. LENGTH OF STAY IN 1b: — —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6004 Winnebago Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Echo Heights
d. STREET ADDRESS: 6004 Winnebago Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle A. — Last Loftus

4. DATE OF DEATH: Month August — Day 13, — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-2-1911

9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Economist

10b. KIND OF BUSINESS OR INDUSTRY: World Bank

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J. Loftus

14. MOTHER'S MAIDEN NAME: M. Mullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No.

(If yes give war or dates of service): — — —

16. SOCIAL SECURITY NO.: 216-16-3997

17. INFORMANT — Address: Ronald P. Loftus- See Item #2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — 16 years.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Posterior Inferior Cerebellar Artery Thrombosis — 3 months.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from MARCH, 1953 to August 13, 1966, that (I) (~~we~~) last saw the deceased alive on August 4, 1966, and that death occurred at 6:13 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Warren D. Brill, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 13, 1966

22c. PHYSICIAN'S NAME (Type): Warren D. Brill

22d. ADDRESS: 2601 16th St. N.W. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-16-1966

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.

23d. LOCATION (City, town or county) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR — ADDRESS: Joseph Gawler's Sons Inc. 5130 Wisc. Ave. N.W. Wash. DC.

25a. REC'D BY REGISTRAR DATE: AUG 16 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

Items 18-21 Film 381 9-29

1 (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11593

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11586

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 1 MO
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 8111 TAHONA DR. #G2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOHN Middle STUART Last LOOMIS
4 DATE OF DEATH: Month AUG. Day 27 Year 1966

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9-18-42
9 AGE (In years last birthday): 23 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DATA PROCESSOR
10b KIND OF BUSINESS OR INDUSTRY: BANKING
11 BIRTHPLACE (State or foreign country): NEW YORK
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: DONALD O. LOOMIS
14 MOTHER'S MAIDEN NAME: SUZON GROUT

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO.: 230-56-3396
17. INFORMANT: Mr. Donald Loomis — Address: 1600 N. ROSELLE ST ARLINGTON, VA

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Multiple extreme, internal injuries — INTERVAL BETWEEN ONSET AND DEATH:
X 21 4
DUE TO
(b): with massive intrathoracic hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Deceased lost control of motorcycle and was thrown under a parked car
20c TIME OF INJURY Month, Day, Year (hour a.m. or p.m.): 4:30 pm 8-27 1966
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f (City or town) (County) (State): N. Hyattsville Pr. Geo. Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Repp M.D.
EXAMINER'S NAME (Type): BELDEN R. REPP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Rockville
22. DATE SIGNED: 8/28/1966

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 9-1-66
23c NAME OF CEMETERY OR CREMATORY: CANFIELD VILLAGE
23d LOCATION (City or Town) (County) (State): CANFIELD OHIO

24 FUNERAL DIRECTOR: W W CHAMBERS & SONS — ADDRESS: RIVERDALE, MD
25a REC'D BY REGISTRAR DATE: AUG 30 1966
25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11593

CERTIFICATE OF DEATH

11587

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 206 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Virginia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McLean
d. STREET ADDRESS: 7907 Ariel Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Susan — Middle: Leigh — Last: LORDEN

4. DATE OF DEATH: Month: August — Day: 18 — Year: 19 66

5 SEX: Female

6. COLOR OR RACE: Cauc.

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Nov. 19, 1944

9 AGE (In years last birthday): 21 yrs

IF UNDER 1 YEAR: Months: 8 — Days: 29

IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Gulfport, Mississippi

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kenneth M. Beyer

14. MOTHER'S MAIDEN NAME: Barbara H. Hemphill

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: Unknown

17 INFORMANT: Bethesda — Address: Md.
Lawrence Lorden, Security Office, NNMC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Confluent bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cerebral anoxia — 8 mos
DUE TO (c): Grand mal convulsion & cardiac arrest — 8 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia; Pituitary necrosis; Acute Splenitis during 8th month pregnancy. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 24, 19 66, to Aug. 18, 19 66, that (I) (we) last saw the deceased alive on Aug. 18 1966, and that death occurred at 4:15 PM, from causes and on the date stated above.

22a SIGNATURE: W. L. Brannon Jr. M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Wm. L. Brannon, Jr., M. D. — 22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial-transit 8-19-66 — 23b. DATE THEREOF — 23c NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery — 23d LOCATION (City or Town) (County) (State): Chicago, Illinois

24 FUNERAL DIRECTOR: R. A. Pumphrey — ADDRESS: Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.

25a RECD BY REGISTRAR DATE: AUG 24 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11594 (M) 11588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery (in) MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 1 yr. - 10 da
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Res MD Y Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
STATE: D.C. COUNTY: 3727 VAN NESS N.W.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D.C.
d. STREET ADDRESS: 3727 VAN NESS ST. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGIT Middle — Last Lukacs
4. DATE OF DEATH: Month August Day 26 Year 1966
5. SEX: Fe
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb 18 1884
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: — —
11. BIRTHPLACE (County & State, or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? Austria
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Edward Batschelet Address 4705-49th St NW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: Months
DUE TO
(b): Bronchopneumonia
DUE TO
(c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pemphigus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 1st, 19 65 to August 26 19 66 that (I) (we) last saw the deceased alive on 8/25/66 and that death occurred at 2 pm M, from causes and on the date stated above.

22a. SIGNATURE: Stephen F. Verges M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 8/26/66
22c. PHYSICIAN'S NAME (Type): Stephen F. Verges
22d. ADDRESS: 5721 Broxburn Lane

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-29-1966
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State): Washington D C

24. FUNERAL DIRECTOR: Joseph Gawler Sons ADDRESS: Washington D.C. 5130 Wisc. Ave. NW.
25a. REC'D BY REGISTRAR DATE: AUG 31 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11585 11589

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 26 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 4018 David Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hugh — Middle: Palmer — Last: LYON Jr

4. DATE OF DEATH: Month: 29 August — Day — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 17 Dec 1942

9. AGE (In years last birthday): 23 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country): Pensacola, Florida

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hugh Palmer Lyon Sr

14. MOTHER'S MAIDEN NAME: Betty Arnold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: "NA"

17. INFORMANT: Address: 4018 David Lane
Mr. Hugh P. Lyon Sr. Alexandria, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic renal failure — INTERVAL BETWEEN ONSET AND DEATH
593X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 4 August, 19 66, to 29 August 19 66, that (X) (we) last saw the deceased alive on 29 August 19 66, and that death occurred at 11:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Raymond B. Johnson M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 30 August 1966

22c. PHYSICIAN'S NAME (Type): Raymond B. Johnson LT MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 31/1966

23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park Cemetery

23d. LOCATION (City or Town) (County) (State): Falls Church, Va.

24. FUNERAL DIRECTOR: L.W. Nester 472 No. Washington Street, Pearson Funeral Home Falls Church, Virginia

25a. RECD BY REGISTRAR DATE: SEP 1 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11595 11590

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San. Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10309 Brookmoor Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: Josephine — Last: Madden
4. DATE OF DEATH: Month: 8 — Day: 23 — Year: 19 66
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-29-1896
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Wash-D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Edward Lynch
14. MOTHER'S MAIDEN NAME: Johanna Dunn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 579-44-0259
17. INFORMANT (Address): (Hus.) Mr John E. Madden

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: immed
DUE TO (b): Hypertensive Arteriosclerotic
DUE TO (c): Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Mar, 19 5~~6~~, to Aug, 19 66, that (I) (~~we~~) last saw the deceased alive on 8/22/1966, and that death occurred at 1635 hrs. P.M., from causes and on the date stated above.

22a. SIGNATURE: Bernard A. Fitzgerald M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-23-66
22c. PHYSICIAN'S NAME (Type): BERNARD A. FITZGERALD
22d. ADDRESS: 217 Univ. Blvd. E, Sil. Sp. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8-26-66
23c. NAME OF CEMETERY OR CREMATORY: Gate-of-Heaven Cemetery
23d. LOCATION (City or Town) (County) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR: Francis J. Collins — ADDRESS: 3821-14th St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: AUG 25 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

Cleared with Medical Examiner, Sex

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11597

CERTIFICATE OF DEATH

11591

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 2320 Pinneberg Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 2320 Pinneberg Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle HOLLAND Last MADER

4. DATE OF DEATH: Month August Day 12, Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 21 Oct. 1915

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer, Mechanical

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (County & State, or foreign country): Mass.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Alfred Mader

14. MOTHER'S MAIDEN NAME: Catherine Reilly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 007-05-9773

17. INFORMANT: Eileen L. Mader Address: Item # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Thrombosis — 24 hrs.
DUE TO (c): Coronary Atherosclerosis — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
HBP

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/1, 1958, to 8/12, 19 66, that (I) (we) last saw the deceased alive on 8/12/1966, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Stephen N. Jones M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/12/66

22c. PHYSICIAN'S NAME (Type): Stephen N. Jones

22d. ADDRESS: 809 Viers Mill Road, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/16/66

23c. NAME OF CEMETERY OR CREMATORY: Arlington ational

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11592

CERTIFICATE OF DEATH

M 11598

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 1/2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chillum
d. STREET ADDRESS: 1208 Riggs Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: KENNETH — Middle: T. — Last: MALCOLM

4. DATE OF DEATH: Month: 8 — Day: 23 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 5-17-90

9. AGE (In years last birthday): 76 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Refrigeration Mech.

10b. KIND OF BUSINESS OR INDUSTRY: Meadow Gold

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Horace G. Malcolm

14. MOTHER'S MAIDEN NAME: Katherine Layton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO: 577-10-8425

17. INFORMANT: William Malcolm — Address: 1208 Riggs Road Chillum, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 42.3

INTERVAL BETWEEN ONSET AND DEATH: (a) 5 days; (b) 14 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible], and that death occurred at [illegible] M, from causes and on the date stated above.

22a. SIGNATURE: [illegible] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 23, 1966

22c. PHYSICIAN'S NAME (Type): Hugh Irey

22d. ADDRESS: [illegible] MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: August 26, 1966

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

23d. LOCATION (City or Town) (County) (State): Washington, D. C

24. FUNERAL DIRECTOR: C. Glenn Carter — ADDRESS: 8434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 26 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Items 18&21 Film 380 9-9-66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11599

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11593

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c LENGTH OF STAY IN 1b: 9 hours
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE: District of Columbia — b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d STREET ADDRESS: 7311 12th Street, NW
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Bridgett — Middle: — Last: Mantua

4 DATE OF DEATH: Month, Day, Year: August 4, 1966

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: December 8, 1905
9 AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Home
11 BIRTHPLACE (State or foreign country): Ireland
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Patrick Moore
14 MOTHER'S MAIDEN NAME: Mary Hutchison

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT: Mrs. Phillip J. Mantua — Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Diabetic acidosis precipitated by
DUE TO
(b): acute, severe, suppurative pyelonephritis
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): BELDEN R. REAP, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Silver Spring
22. DATE SIGNED: Aug. 5, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 8, 66
23c NAME OF CEMETERY OR CREMATORY: Gate of Heaven
23d LOCATION (City or Town) (County) (State): Silver Spring, Maryland

24 FUNERAL DIRECTOR: N. K. Hunteemann & Son — ADDRESS: 5736 Georgia Ave. N.W.
25a REC'D BY REGISTRAR DATE: AUG 8 1966
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11600 11594

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md
c. LENGTH OF STAY IN 1b: 22 years.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Oakhaven Convalescent Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 1529 - 28th St. S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary Middle: E Last: Mayer
4. DATE OF DEATH: Month: Aug Day: 10 Year: 1966
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 16, 1882
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Micheal Hickey
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Connelly.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT Address: Karl Weimar, 5605 Southwick Bethesda Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Kidney Infection — yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cystitis — yrs.
DUE TO (c): — yrs.
INTERVAL BETWEEN ONSET AND DEATH: 2 Yrs 7 Mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 19 66, to Aug 10, 19 66, that (I) (we) last saw the deceased alive on 8/10/ 19 66, and that death occurred at 2:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: C H Wolohon — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-10-66
22c. PHYSICIAN'S NAME (Type): Chas H Wolohon
22d. ADDRESS: 1401 Blair Rd NW Washington DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/13/66
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges Co. Md.

24. FUNERAL DIRECTOR ADDRESS: The S. H. Hines Co. Washington, D.C.
25a. REC'D BY REGISTRAR DATE: AUG 11 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11601

CERTIFICATE OF DEATH

11595

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Erie
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Erie
d. STREET ADDRESS: 817 W. 17th St. ~~Erie, Pennsylvania~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna — Middle: Johanna — Last: McCabe

4. DATE OF DEATH: Month: August — Day: 10 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/21/06
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania,
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: John Nelson
14. MOTHER'S MAIDEN NAME: Emma Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 194-14-9989
17. INFORMANT — Address: Husband and hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):
I 201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 8/5, 1966, to 8/10, 1966, that (I) ~~(we)~~ last saw the deceased alive on 8/10 1966, and that death occurred at 4:55 P.M., from causes and on the date stated above.

22a. SIGNATURE: Charles S. Whitaker, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/11/66
22c. PHYSICIAN'S NAME (Type): CHARLES S. WHITAKER, M.D.
22d. ADDRESS: CLARKSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-15-1966
23c. NAME OF CEMETERY OR CREMATORY: Johnsonburg
23d. LOCATION (City or Town) (County) (State): Johnsonburg, Penna.

24. FUNERAL DIRECTOR — ADDRESS: Higinbotham Funeral Home, Ellicott City, Md.

25a. REC'D BY REG.STRAR — DATE: AUG 15 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11602 — 11596

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: [illegible] b. COUNTY: Washington, D.C.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RESTOR SANITARIUm & HOSPITAL	d. STREET ADDRESS: 1600 32nd St N.W. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cornelia — Middle: M. — Last: McNary	4. DATE OF DEATH: Month: August — Day: 23 — Year: 19 66						
5. SEX: Female	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: May 30, 1890	9. AGE (In years last birthday): 76 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: - - -	11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME: Bruce Voton Morton	14. MOTHER'S MAIDEN NAME: Mary Lowry						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): generalized Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 10, 1966, to Aug 23, 1966 that (I) (we) last saw the deceased alive on Aug. 22 1966, and that death occurred at 1:50 AM from causes and on the date stated above.

22a. SIGNATURE: Stephen F. Verges M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: Aug 23, 1966		
22c. PHYSICIAN'S NAME (Type): Stephen F. Verges, M.D.	22d. ADDRESS: 5721 Fremont Lane		
23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE THEREOF: 8-24-1966	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State): Suitland, Md.
24. FUNERAL DIRECTOR — ADDRESS: Joseph Dawley Sons by M Patterson	25a. RECD BY REGISTRAR DATE: AUG 26 1966	25b. REGISTRAR'S SIGNATURE: Charles Judge	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11603 — 11597

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
d. STREET ADDRESS: 2827 Sudberry Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Rebecca — Middle: L. — Last: Messerschmidt

4 DATE OF DEATH: Month: August — Day: 23 — Year: 19 66

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-12-66
9. AGE (In years last birthday): — yrs. — IF UNDER 1 YEAR: Months — Days: 10 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Elmer Oscar Messerschmidt
14. MOTHER'S MAIDEN NAME: Edna Lou Queen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: mother — Address: SAME AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-1-2, 19 66, to 8-23, 19 66, that (I) (we) last saw the deceased alive on 8-23-66 19, and that death occurred at 6:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Richard Hollander M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Richard Hollander
22d. ADDRESS: 1110 Spring ST. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 25 1966
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
23d. LOCATION (City or Town) (County) (State): Colmar Manor, P.G. Md

24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md
25a. REC'D BY REGISTRAR DATE: AUG 29 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

11634

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11598

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 11 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gibson Island
d. STREET ADDRESS: Box 72, Rackham Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Wellman — Last: MITCHELL, Jr.

4. DATE OF DEATH: Month: August — Day: 28 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9 June 1899

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Naval Officer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Wellman Mitchell Sr.

14. MOTHER'S MAIDEN NAME: Florence M. Crowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Nannie D. Mitchell
Address: Box 72, Rackham Road, Gibson Island, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured arteriosclerotic aneurysm, left common Iliac artery — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Chronic emphysema with organizing bronco pneumonia, bilateral
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (☒ this hospital) attended the deceased from 18 August, 19 66, to 28 August, 19 66 that (☒ we) last saw the deceased alive on 28 August 19 66 and that death occurred at 5:00A M, from causes and on the date stated above.

22a. SIGNATURE: F. H. O'Connell M.D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 29 August 1966

22c. PHYSICIAN'S NAME (Type): F. H. O'Connell CDR MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-31-1966

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

23d. LOCATION (City or Town) (County) (State): Arlington Va.

24. FUNERAL DIRECTOR: Joseph Gawler & Sons 5130 Wisconsin Avenue, N.W. Washington, D.C.

25a. REC'D BY REGISTRAR DATE: SEP 6 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Items 18-21 Film 382 11-1-

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11605

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11599

1 PLACE OF DEATH a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c LENGTH OF STAY IN 1b: 4 months
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 12309 Brafield Ct. Apt. 9

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE: Maryland — COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rockville
d STREET ADDRESS: 12309 Brafield Ct. #9 Apt
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First EARL — Middle Hugh — Last MITCHELL SR.
4 DATE OF DEATH: Month 8 — Day 31 — Year 1966

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8 DATE OF BIRTH: 5-24-1917
9 AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher Principal
10b KIND OF BUSINESS OR INDUSTRY: Education
11 BIRTHPLACE (State or foreign country): Oklahoma
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: Edward Mitchell
14 MOTHER'S MAIDEN NAME: Vernon Walner

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service): WW II
16 SOC. A. SECURITY NO: 441-22-1236
17 INFORMANT: (Wife) Thelma Mae Mitchell — Address: (SAME)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiorespiratory failure due to — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): overdose of Carbrital, self-administered
DUE TO
(c):
470.2

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Deceased, depressed, took overdose of barbiturate.
20c TIME OF INJURY Month, Day, Year: 8-31 1966 — Hour—a.m. p.m.: 2:00
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): Home
20f (City or town) (County) (State): Rockville Montgomery Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): BELDEN R. REAP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, City, Zip or county): Wheaton
22. DATE SIGNED: Sept. 1, 1966

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: Sept. 3, 1966
23c NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
23d LOCATION (City or Town) (County) (State): Arlington, Virginia

24 FUNERAL DIRECTOR: Clark E. Wilson — Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Ave. Silver Spring, Md.
25a REC'D BY REGISTRAR: DATE SEP 7 1966
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11603

CERTIFICATE OF DEATH

11600

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Clarksburg~~ Silverspring
c. LENGTH OF STAY IN 1b: 1 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: not known
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
d. STREET ADDRESS: P. O. Box 62
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE Middle Franklin Last ~~Mobley~~ MOBLEY, CLARENCE FRANKLIN

4. DATE OF DEATH: Month Aug 17th Day Year 19 66

5. SEX: Male
6. COLOR OR RACE: Caus.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/9/1888
9. AGE (In years last birthday): ~~77~~ 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Gaithersburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Mobley
14. MOTHER'S MAIDEN NAME: Harriet Selby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Samuel H. Mobley, As No 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis; Chronic Brain Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7-15, 1966, to 8-17, 1966, that (I) (we) last saw the deceased alive on 8-16 1966, and that death occurred at 7:[illegible] A M, from causes and on the date stated above.

22a. SIGNATURE: Irwin H Ardam Jr M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8-17-66
22c. PHYSICIAN'S NAME (Type): Dr. Irwin Ardam
22d. ADDRESS: 1712 I St., NW, Washington, D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-20-66
23c. NAME OF CEMETERY OR CREMATORY: Forest Oak
23d. LOCATION (City or Town) (County) (State): Gaithersburg Md

24. FUNERAL DIRECTOR: Ernest C. Gartner — ADDRESS: Gaithersburg Md
25a. REC'D BY REGISTRAR DATE: AUG 19 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 Film #G320 8/25/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11607 — Item 11 Film G360 9/6/66 mh — 11601

1 FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 9 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~West~~ D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington.
d. STREET ADDRESS: 2900 Conn. Ave NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Marjorie — Middle: E. — Last: Morgan

4. DATE OF DEATH: Month: August 9th — Day — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/21/97 98

9. AGE (In years last birthday): 68 69 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Management Anaylist

10b. KIND OF BUSINESS OR INDUSTRY: V.A.

11. BIRTHPLACE (State or foreign country): Indiana Van Wert, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David H. Morgan

14. MOTHER'S MAIDEN NAME: Mae R. Freeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO: ---

17. INFORMANT: Virginia VanDuyne — Address: 51 Annin Rd. West Caldwell, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Obstruction, Small Intestine
DUE TO (b): due to hernia, rt. femoral, incarcerated
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Ball M D

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 8/10/66

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 8/13/66

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Suitland, Md.

24. FUNERAL DIRECTOR — ADDRESS: The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.

25a. REC'D BY REGISTRAR: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

LE 1

FOR STATE HEALTH DEPT.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11603

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

-1602

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chillum
d. STREET ADDRESS: 1107 Burketon Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle Dominic Last MULLOY

4. DATE OF DEATH: Month AUG. Day 22 Year 1966

5. SEX: M

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 7, 1908

9. AGE (In years last Birthday): 57 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Projectionist

10b. KIND OF BUSINESS OR INDUSTRY: Theatre

11. BIRTHPLACE (State or foreign country): Washington D C

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur D Mulloy

14. MOTHER'S MAIDEN NAME: Annie Shea

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 578-05-6541

17. INFORMANT: Mrs. Mayelle Mulloy (Wife) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Artery Heart Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BELDEN R. REAP M.D. Address (Street, city, town or county): Hyattsville

22. DATE SIGNED: 8/23/1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-26-66

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town or county) (State): Suitland Md.

24. FUNERAL DIRECTOR: Lee Funeral Home ADDRESS: Washington D C

25a. REC'D BY REGISTRAR DATE: AUG 30 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11689 — 11603

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from state; in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4408 Enden Court

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 4408 Enden Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cleo — Middle: — Last: Nancollas
4. DATE OF DEATH: Month: 8 — Day: 1 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-10-1903
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Lady
10b. KIND OF BUSINESS OR INDUSTRY: Woodward & Lothrop/ Pennsylvania
11. BIRTHPLACE (County & State, or foreign country): U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Clement John Berschneider
14. MOTHER'S MAIDEN NAME: Annie May

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service): — — —
16. SOCIAL SECURITY NO.: — —
17. INFORMANT — Address: Alfred E. Nancollas- See Item #2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Adenocarcinoma of rectosigmoid colon — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO
154X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October 23, 1965, to Aug 1, 1966, that (I) (we) last saw the deceased alive on July 29 1966, and that death occurred at 10:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Blaine H. Eig — M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 1, 1966
22c. PHYSICIAN'S NAME (Type): Blaine H. Eig
22d. ADDRESS: 8641 Colesville Rd Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-5-1966
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery- Silver Spring, Md.
23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc.
ADDRESS: 5130 Wisc. Ave. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: AUG 5 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18&20 Film 380 8-23

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 Hours after death If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11610

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11604

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Prince Georges
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d STREET ADDRESS: 2510 Woodbury ST
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Ronald — Middle Andrew — Last Nazit
4 DATE OF DEATH: Month August — Day 13 — Year 1966

5 SEX: male
6 COLOR OR RACE: white
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 8/9/43
9 AGE (In years last birthday): 23 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Army Map Service
10b KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11 BIRTHPLACE (State or foreign country): Penna.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Andrew M. Nazit
14 MOTHER'S MAIDEN NAME: Rose Zentack

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service)
16 SOCIAL SECURITY NO:
17. INFORMANT — Address: Sister - Genevieve Steiger - SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Injuries Multiple and severe — INTERVAL BETWEEN ONSET AND DEATH: instant
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Automobile accident
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Automobile hit bridge abutment, turned over, threw deceased out of car
20c TIME OF INJURY Month, Day, Year Hour a.m.: 11 pm 13 Aug 1966
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f (City or town) (County) (State): Montgomery Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): W. Shumpley M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county)
22. DATE SIGNED: 14 aug 66

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Aug 17 1966
23c NAME OF CEMETERY OR CREMATORY: St aloysius
23d LOCATION (City or Town) (County) (State): Cresson Pa

24. FUNERAL DIRECTOR: W.W. Talbert — ADDRESS: 3603 14th St NW Wash DC

25a REC'D BY REGISTRAR DATE: AUG 16 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M 11611 Item #2d Film #0382 11/1/66 pg

CERTIFICATE OF DEATH

i1605

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 20 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH SANITARIUM & HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD
b. COUNTY: P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
d. STREET ADDRESS: 1420 University Blvd Apt. 301
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle BUCKLEY Last NEAL

4. DATE OF DEATH: Month 8 Day 1 Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-12-01

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MEAT CUTTER

10b. KIND OF BUSINESS OR INDUSTRY: GM MARKET

11. BIRTHPLACE (County & State, or foreign country): KENTUCKY

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ARCH S. NEAL

14. MOTHER'S MAIDEN NAME: SOPHIA BUCKLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NAW (If yes give war or dates of service): 11-22

16. SOCIAL SECURITY NO: —

17. INFORMANT: CHART Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b): Arteriosclerotic Heart Disease — 4 YRS.
DUE TO
(c): Diabetes Mellitus — 4 YRS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-11, 19 66 to 8/1, 19 66 that (I) (we) last saw the deceased alive on 8/1 1966, and that death occurred at 4:30 from causes and on the date stated above

22a. SIGNATURE: Wm H. Gillespie M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8/1/66

22c. PHYSICIAN'S NAME (Type): ALBERT H COLEMAN MD

22d. ADDRESS: 1106 SPRING ST. SILVER SPRING

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: August 4-1966

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) Arlington (County) (State) Va.

24. FUNERAL DIRECTOR: Arthur Walters ADDRESS: 254 Carroll St. N.W. Washington D.C.

25a. REC'D BY REGISTRAR DATE: AUG 3 1966

25b. REGISTRAR'S SIGNATURE: J Charles Jordan

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11612

CERTIFICATE OF DEATH

11606

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Charlotte
d. STREET ADDRESS: 1418 Kenilworth Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anne — Middle Elizabeth — Last Neill

4. DATE OF DEATH: Month August — Day 16, — Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5 April 1899

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months 4, Days 11 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School teacher

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William T. McKee

14. MOTHER'S MAIDEN NAME: Stella Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: Unascertainable

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: ? 1 week

1950

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cushing's disease — 1½ years
DUE TO (c): Left adrenal carcinoma — 1½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from August 3, 1966, to August 16, 1966, that ☐ (we) last saw the deceased alive on August 16 1966, and that death occurred at 10:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Dr David Pleasure — M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: August 16, 1966

22c. PHYSICIAN'S NAME (Type): David Pleasure, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit

23b. DATE THEREOF: 8-17-66

23c. NAME OF CEMETERY OR CREMATORY: Sylvan Heights Cem.

23d. LOCATION (City, town or county) (State): Uniontownship, Penna.

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: AUG 19 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11613 11607

1 PLACE OF DEATH a COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c LENGTH OF STAY IN 1b: 7 Years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland b COUNTY: Montgomery
c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 4113 Woodbine Street
d. STREET ADDRESS: Chevy Chase
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: WINSLOW Middle: H. Last: NESBITT
4. DATE OF DEATH Month: Aug. Day: 19, Year: 19 66

5. SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Dec. 3, 1878
9 AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR Months: 8 Days: 16
IF UNDER 24 HRS Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Fred Hutchinson
14. MOTHER'S MAIDEN NAME: ANNIE WHITESIDE

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17 INFORMANT: Son Edward Nesbitt Address: 2228-40th Pl., N.W. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia. Bronchial -	5 days
DUE TO (b)	Uremia -	24 days
DUE TO (c)	Generalized - Arterio Sclerosis.	Years

4500

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1948 -, 19 to date, 19 , that (I) (we) last saw the deceased alive on Aug 16 1966, and that death occurred at 10:05 A.M., from causes and on the date stated above.

22a. SIGNATURE: John G. Ball M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: Aug. 19, 1966
22c. PHYSICIAN'S NAME (Type): JOHN G. BALL
22d. ADDRESS: 7936 Old Georgetown Rd. Bethesda, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-23-66
23c. NAME OF CEMETERY OR CREMATORY: Arlington Natl Cem.
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, ADDRESS: Bethesda, Maryland
25a REC'D BY REGISTRAR DATE: AUG 24 1966
25b REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11614 — 11608

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA — c. LENGTH OF STAY IN 1b: 10 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DERWOOD
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN	e. STREET ADDRESS: RT 1 Box 233 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ANNA	LEE	NICHOLSON	August	13	1966

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min
FEMALE	WHITE	MARRIED ☒	2/19/15	51 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	Home	Virginia	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Ennis	Bertie Redmond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
No	579-28-1500	Walter Nicholson	RFD 1 Box 253, Derwood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Renal Insufficiency - Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO (b): Hepatorenal Syndrome

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c): Cirrhosis Liver — 1 Month.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 3, 1966, to August 13, 1966, that (I) (~~was~~) last saw the deceased alive on August 13 1966, and that death occurred at 11 ST AM, from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNED
J. Blaine Fitzgerald		☐	☐	☒	8-14-66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
J. Blaine Fitzgerald	Bethesda Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	8-17-66	Laytonsville	Laytonsville, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis H. Barber	Laytonsville, Md.	AUG 16 1966	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11615

CERTIFICATE OF DEATH

i1609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring Md.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
   d. STREET ADDRESS: 3201 Gillis Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: Victoria — Last: Odelson

4. DATE OF DEATH: Month: 8 — Day: 10 — Year: 1966

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 25 1889

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Wash. D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Smith Camp

14. MOTHER'S MAIDEN NAME: Anna Brunner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 577-03-0582

17. INFORMANT: Fred H. Hammer — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 5 / 10

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Gangrenous cholecystitis
DUE TO (c): Acute pancreatitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-8-66, 19__ to 8-10-, 1966, that (I) (we) last saw the deceased alive on 8/10 1966, and that death occurred at 8 40 M, from the causes and on the date stated above.

22a. SIGNATURE: Morris Perry M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/10/66

22c. PHYSICIAN'S NAME (Type): Morris Perry, M.D.

22d. ADDRESS: 11602 Georgia Ave. Wheaton Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/13/66

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

23d. LOCATION (City, town or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR — ADDRESS: The S. H. Hines Co. Washington, D. C.

25a. REC'D BY REGISTRAR DATE: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11613

CERTIFICATE OF DEATH

11610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lewisdale
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lewisdale
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Laurence — Middle: — Last: Offutt
4. DATE OF DEATH: Month: August — Day: 27 — Year: 1966
5. SEX: M
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 30, 1901
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Dora Offutt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Vascular-Renal Disease with Congestive — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO (b): Cardiac Failure. Terminal Acute Dilatation of Heart. — Sudden.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No Injury
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 22, 1966 to Aug. 27, 1966, that (I) (we) last saw the deceased alive on Aug. 27, 1966, and that death occurred at 12:38 A.M. P.M. from causes and on the date stated above.

22a. SIGNATURE: M. McKendree Boyer M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): M. McKendree Boyer, M. D.
22d. ADDRESS: 9701 Church Street, Damascus, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/31/66
23c. NAME OF CEMETERY OR CREMATORY: Lincoln Park
23d. LOCATION (City or Town) (County) (State): Rockville, Md.
24. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.
25a. RECD BY REGISTRAR DATE: SEP 2 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18-21 Film 382 11-1

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11617

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11611

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2710 Henderson Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howa rd — Middle: ~~Xxxxxx~~ Clarence — Last: Overby
4. DATE OF DEATH: ~~Xxx~~ Aug, ~~Xxx~~ 29 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11, Aug, 13
9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail clerk
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Govt.
11. BIRTHPLACE (State or foreign country): Charlottesville ~~Xxxxxxxxxx~~ Spgs., N. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Overby
14. MOTHER'S MAIDEN NAME: ~~Xxxxxxx~~ Stephonie Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO: 577-20-8754
17. INFORMANT: Elsie M. Overby — Address: 2710 Henderson Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple, extreme, internal injuries.
DUE TO
(b): with exsanguination
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Deceased, driving auto, was struck by another auto which ran through red light.
20c. TIME OF INJURY Month, Day, Year: Hour a.m. 6:20 p.m. 8-29 1966
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) (County) (State): Silver Spring Montg. Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): BELDEN R. REAP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Wheaton
22. DATE SIGNED: 8-29-1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 1, 1966
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.

24. FUNERAL DIRECTOR: Clark & Wisor Clark-Eakins Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Ave. Silver Spring, Md.
25a. RECD BY REGISTRAR DATE: AUG 31 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15ME (5) 6M 1/66

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11618 **CERTIFICATE OF DEATH** 11612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Viewed by County Medical Examiner

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring Rural
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box #68

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring Rural
d. STREET ADDRESS: Box #68
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FAIRY — Middle: LOU — Last: OWENS.

4. DATE OF DEATH: Month: August — Day: 25, — Year: 1966.

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 15, 1904

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Shults

14. MOTHER'S MAIDEN NAME: Martha Shepherd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Fred Owens — Address: Route 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5-10 Min
DUE TO (b): Possible Pulmonary embolus, acute — 5-10 Min
DUE TO (c): arteriosclerotic heart disease — years

I 201
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cancer breast. Radical Mastectomy (right) June 66

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) this hospital attended the deceased from Oct 9, 1963, to Aug 25, 1966, that (I) (we) last saw the deceased alive on Aug 14 1966, and that death occurred at 4:40 PM, from the causes and on the date stated above.

22a. SIGNATURE: John R Spencer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-25-66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: BURTONSVILLE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify):

23b. DATE THEREOF: Aug-27-1966

23c. NAME OF CEMETERY OR CREMATORY: St. Martin's

23d. LOCATION (City, town or county) (State): Fairland Montg Md

24. FUNERAL DIRECTOR: Harold Stalter — ADDRESS: 254 Carroll St. N.W.

25a. RECD BY REGISTRAR DATE: AUG 29 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11619

CERTIFICATE OF DEATH

11613

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 39 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Rhode Island — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Providence
d. STREET ADDRESS: 470 Blackstone Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bruce — Middle: Steven — Last: Pansey

4. DATE OF DEATH: Month: August — Day: 13 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 24, 1942

9. AGE (In years last birthday): 24 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreign Service Officer

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (County & State, or foreign country): Rhode Island

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Neil Pansey

14. MOTHER'S MAIDEN NAME: Antoinette Tucci

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Not available

17. INFORMANT: The Medical Records — Address: The Clinical Center, NIH, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant Melanoma — INTERVAL BETWEEN ONSET AND DEATH: 15 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from July 5, 1966 to August 13, 1966, that I (we) last saw the deceased alive on August 13, 1966, and that death occurred at 5:50 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Paul Neiman — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 14 August 1966

22c. PHYSICIAN'S NAME (Type): Paul Neiman, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/15/66

23c. NAME OF CEMETERY OR CREMATORY: CONG. SONS OF ISRAEL & DAVID

23d. LOCATION (City, town or county) (State): PROVIDENCE R.I.

24. FUNERAL DIRECTOR: GOLDBERG FUNERAL HOME — ADDRESS: 4217-9th St. N.W.

25a. REC'D BY REGISTRAR DATE: AUG 16 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11620 — 11614

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Prince Georges ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
d. STREET ADDRESS: 7773 Riverdale Road, Apt. 103
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Natalie — Middle: Ann — Last: Parris
4. DATE OF DEATH: Month: August — Day: 20, — Year: 19 66
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 9 September 1938
9. AGE (In years last birthday): 27 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Education
11. BIRTHPLACE (County & State, or foreign country): Maryland Takoma Park
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Roger F. Burdette
14. MOTHER'S MAIDEN NAME: Lorraine Baker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ---
16. SOCIAL SECURITY NO.: 214-36-4942
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hodgkin's disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized varicella (5 days)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from July 30, 19 66, to August 20 19 66, that ☒ (we) last saw the deceased alive on August 20 19 66, and that death occurred at 1:55 A.M., from the causes and on the date stated above.
22a. SIGNATURE: Paul Neiman M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 20 August 1966
22c. PHYSICIAN'S NAME (Type): Paul Neiman M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/23/66
23c. NAME OF CEMETERY OR CREMATORY: George Washington
23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR: Malley's Funeral Home, Inc. — ADDRESS: 3200 R.I. Ave. Mt. Rainier Md.
25a. REC'D BY REGISTRAR DATE: AUG 29 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11621 — 11615

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 8 Louden Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Alexandra — Middle: Leith — Last: PATTERSON

4. DATE OF DEATH: Month: August — Day: 25 — Year: 19 66

5 SEX: Female
6 COLOR OR RACE: Cauc
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 24 April 1902
9 AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: NA
11 BIRTHPLACE (County & State, or foreign country): Springfield, Mass.
12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: Alexander Leith
14 MOTHER'S MAIDEN NAME: Minnie Stuart

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16 SOCIAL SECURITY NO: 217-48-8142
17. INFORMANT: George W. Patterson — Address: 8 Louden Lane, Wardour, Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Uremia and duodenal ulceration with hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I (this hospital) attended the deceased from 5 August, 1966, to 25 August 1966, that I (we) last saw the deceased alive on 25 August 19 66, and that death occurred at 6:00 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 26 August 1966
22c. PHYSICIAN'S NAME (Type): J. B. EMERY JR. LT MC USN
22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-29-1966
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City or Town) (County) (State): Arlington, Arlington, Va.

24. FUNERAL DIRECTOR: John M. Taylor & Sons
ADDRESS: 147 Duke of Glouster St. Annapolis, Maryland
25a REC'D BY REGISTRAR DATE: AUG 30 1966
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and, in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11622

CERTIFICATE OF DEATH

11616

1 PLACE OF DEATH
a. COUNTY ~~Prince~~ Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton
c. LENGTH OF STAY IN 1b 10 wks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) Randolph Hills Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Md. b. COUNTY Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d STREET ADDRESS 5905 Halsey Rd.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Allie Middle: Bell Lost: Pennington
4 DATE OF DEATH Month: 8 Day: 20 Year: 1966

5. SEX: F
6. COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8a DATE OF BIRTH: Oct 20, 1886
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Virginia - Floyd Co.
12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Walter Akers
14. MOTHER'S MAIDEN NAME: Elizabeth Hungate

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Goldie Calfee Address 5905 Halsey Rd Rockville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Metastatic hypernephroma — INTERVAL BETWEEN ONSET AND DEATH 8 months
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from ____, 1963 to 8-20, 1966, that (I) (we) last saw the deceased alive on 8-18 1966, and that death occurred at 7:45 M, from causes and on the date stated above.

22a. SIGNATURE Donald L. Bucy M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8-29-66
22c. PHYSICIAN'S NAME (Type) Donald L. Bucy
22d. ADDRESS 809 Veirs Mill Rd Rockville

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 8/22/66
23c. NAME OF CEMETERY OR CREMATORY ~~Forestlawn~~ Rosehill Memorial Gardens
23d. LOCATION (City or Town) (County) (State) Prinston, W. Va.

24. FUNERAL DIRECTOR ADDRESS Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.
25a. REC'D BY REGISTRAR DATE AUG 24 1966
25b REGISTRAR'S SIGNATURE J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11617

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 3 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1216 Clagett Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Jennings — Middle: — Last: PENNINGTON

4. DATE OF DEATH: Month: August — Day: 8 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 8, 1962

9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months: 4, Days: 0 — IF UNDER 24 HRS.: Hours: , Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (State or foreign country): Winchester, Kentucky

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald Robert Pennington

14. MOTHER'S MAIDEN NAME: Sachiko Endo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N/A (If yes, give war or dates of service): N/A

16. SOCIAL SECURITY NO.: -------

17. INFORMANT: Rockville — Address: Md.
Donald Robert Pennington, 1216 Clagett Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries, severe — INTERVAL BETWEEN ONSET AND DEATH: 3 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Trauma from colliding with moving auto
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): child ran in front of car -

20c. TIME OF INJURY Month, Day, Year: Hour 6:00 p.m. 8/8 1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street.

20f. (City or town) (County) (State): Rockville Mont. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): John G. Ball, M. D.

CHIEF MEDICAL EXAMINER ☐ Bethesda, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: August 9, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-10-66

23c. NAME OF CEMETERY OR CREMATORY: Winchester Cemetery

23d. LOCATION (City, town or county) (State): Lexington Ave. Winchester Ky.

24. FUNERAL DIRECTOR — ADDRESS: R. A. Pumphrey Funeral Home, 7557 Wisconsin Ave. Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: AUG 11 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR AISME (5)
5M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11624

CERTIFICATE OF DEATH

11618

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: WASHINGTON — b. COUNTY: King ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEATTLE XXXXXXXXXXXXXXXXXX
d. STREET ADDRESS: 1838 E. Shelby St. ~~1500 FOREST GLEN RD~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LEAH — Middle H. E. — Last PEPPER
4. DATE OF DEATH: Month 8 — Day 18 — Year 1966
5. SEX: F
6. COLOR OR RACE: CAUC
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/9/95
9. AGE (In years Last birthday): 70 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. REGISTRAR
10b. KIND OF BUSINESS OR INDUSTRY: UNIV. OF WASHINGTON
11. BIRTHPLACE (County & State, or foreign country): CANADA
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Albert E. Pepper
14. MOTHER'S MAIDEN NAME: Josephine LaBena Sanderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO: Yes
17. INFORMANT: Vincent Pepper — Address: 14504 Ga. Ave., Silver Spr Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracerebral Hemorrhage
DUE TO (b): C
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 8/17/66 19__ to 8/18/66 19__, that (I) ~~(we)~~ last saw the deceased alive on 8/18/66 19__, and that death occurred at 12:58 P.M. from causes and on the date stated above.

22a. SIGNATURE: John J. Curry — M.D. — ATTENDING PHYS ☐ — MED. DIRECTOR ☐ — STAFF PHYS ☐
22b. DATE SIGNED: 8/18/66
22c. PHYSICIAN'S NAME (Type): John J. Curry
22d. ADDRESS: 10620 Georgia Ave Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 23, 1966
23c. NAME OF CEMETERY OR CREMATORY: Washelli Evergreen Cem.
23d. LOCATION (City or Town) (County) (State): Seattle, Washington

24. FUNERAL DIRECTOR: Clark E. Wisor — ADDRESS: 8434 Georgia Ave Silver Spring, Md.
Clark & Wisor Warner E. Pumphrey, Inc.
25a. REC'D BY REGISTRAR — DATE: AUG 22 1966
25b. REGISTRAR'S SIGNATURE: J Charley Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11625 — 11619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 yr 2 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cedar Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 506 Tulip Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PEARL — Middle: A. — Last: PESTER

4. DATE OF DEATH: Month: AUGUST — Day: 12 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 30, 1879

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: F. J. Shoemaker

14. MOTHER'S MAIDEN NAME: Pauline V. Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Rest Home Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Cerebral Thrombosis
DUE TO (b): Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4½ Days / 20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive Heart Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCR.BE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1958 to Aug. 12, 1966 that (I) (~~we~~) last saw the deceased alive on Aug. 11, 1966, and that death occurred at 12:45 PM, from the causes and on the date stated above

22a. SIGNATURE: Russell B. Arnold M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/12/66

22c. PHYSICIAN'S NAME (Type): Russell B. Arnold M.D.

22d. ADDRESS: 1106 Spring Street Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug-15-1966

23c. NAME OF CEMETERY OR CREMATORY: Hos Hart Cemetery

23d. LOCATION (City, town or county) (State): Prince Georges

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Arthur Walters 254 Carroll St. N.W. Washington, D.C.

25a. RECD BY REGISTRAR DATE: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove remaining papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11625

CERTIFICATE OF DEATH

11620

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Xxxxxxxxxx~~ Takoma Park
c. LENGTH OF STAY IN 1b: 31 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Xxxxxxxxxx~~ Takoma Park
d. STREET ADDRESS: 904 Domer Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mrs. Mary (NMN) Middle: Last: Peto
4. DATE OF DEATH: Month: August Day: 19 Year: 19 66

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-18-93
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Xxxxxxxxxxxxxxxxxx~~ housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A. American

13. FATHER'S NAME: Andrew M. Smith
14. MOTHER'S MAIDEN NAME: Alice Lyon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO: 148-01-6504
17. INFORMANT: Frank Peto ~~Xxxxxxxxxxxxxxx~~ Address: 904 Domer Ave, Takoma Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Congestive Heart Failure
DUE TO
(c): Cerebral Vascular accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331K

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept ____, 19 65, to Aug 19 ____, 19 66, that (I) (we) last saw the deceased alive on Aug 18 19 66, and that death occurred at 2:45 A M, from causes and on the date stated above.

22a. SIGNATURE: Samuel Loube M.D. / S. Schwartz — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/19/66
22c. PHYSICIAN'S NAME (Type): Samuel Loube, M.D. / S. Schwartz
22d. ADDRESS: MD 2400 H ST. N.W. WASHINGTON D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 22, 1966
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.

24. FUNERAL DIRECTOR: C. Glen Carter Glen Circle
Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Ave. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: AUG 22 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11627

CERTIFICATE OF DEATH

11621

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 3½ hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)
a. STATE Maryland b. COUNTY Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 11709 Galt Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Edna Middle Marie Last Poque
4. DATE OF DEATH Month Y Day 8 Year 1966
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 10/9/94
9. AGE (In years last birthday) 71 ~~72~~ yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (County & State, or foreign country) Penn'a.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME (Unknown)
14. MOTHER'S MAIDEN NAME (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None
16. SOCIAL SECURITY NO 175-03-1068
17. INFORMANT Mrs. Irene L. Rotz Address 11709 Galt Avenue Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO (b) Coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 24 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1954, 19__, to 8-8, 1966, that (I) (we) last saw the deceased alive on 8-8-66 19__, and that death occurred at 4:10 P.M., from causes and on the date stated above.

22a. SIGNATURE Morris Perry M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8-8-66
22c. PHYSICIAN'S NAME (Type) Morris Perry
22d. ADDRESS 11602 Georgia Ave. Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Aug. 12, 1966
23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery
23d. LOCATION (City or Town) (County) (State) Chambersburg, Pennsylvania

24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Ave. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE AUG 11 1966
25b. REGISTRAR'S SIGNATURE J. Charles Lentz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11628 — 11622

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Springs
c. LENGTH OF STAY IN 1b: 12 days

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs, Md.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital
d. STREET ADDRESS: 7416 Lanham Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ann — Middle: C — Last: Polievka
4. DATE OF DEATH: Month: August — Day: 30 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: aug 14-1924
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (County & State, or foreign country): Washington DC
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred Ellis
14. MOTHER'S MAIDEN NAME: Ruth Soper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John J. Polievka — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE RENAL TUBULAR NECROSIS — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): HEPATIC FAILURE
DUE TO (c): FATTY NUTRITIONAL CIRRHOSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/18, 1966, to 8/30, 1966, that (I) (we) last saw the deceased alive on 8/30 1966, and that death occurred at 12:25 PM, from the causes and on the date stated above.

22a. SIGNATURE: Frederick Y. Donn — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/30/66
22c. PHYSICIAN'S NAME (Type): FREDERICK Y. DONN
22d. ADDRESS: 10400 Connecticut Ave, Kensington, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 2-1966
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery, Arlington, Va.
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR: Simmons Bros.
ADDRESS: Simmons Bros. 1661-Gd. Hope Rd. SE Wash., DC
25a. REC'D BY REGISTRAR DATE: SEP 1 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11629

CERTIFICATE OF DEATH

11623

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 23days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: ~~XXXX~~ MD. b. COUNTY: PR. Geo's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~XXXXXXXXXXXX~~ OXON HILL
d. STREET ADDRESS: 6500 Circle Dr. 16-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALFRED Middle E. Lost PRINKEY
4. DATE OF DEATH: Month Aug Day 11 Year 1966
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/31/10
9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Govt.
11. BIRTHPLACE (County & State, or foreign country): Penn.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joshua Prinkey
14. MOTHER'S MAIDEN NAME: Ada Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No None
16. SOCIAL SECURITY NO.: 578-10-1215
17. INFORMANT: Address: LILLIAN S. PRINKEY (wife) #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac tamponade — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Left ventricular rupture — Minutes
DUE TO (c): Myocardial infarction — 25 days
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/18, 1966 to 8/11, 1966 that (I) (we) last saw the deceased alive on 8/11, 1966, and that death occurred at 7:20 AM, from causes and on the date stated above.

22a. SIGNATURE: Robert R. Montgomery M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/11/66
22c. PHYSICIAN'S NAME (Type): ROBERT R. MONTGOMERY
22d. ADDRESS: 5711 Cedar Lane Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: aug 13-1966
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Blad[illegible] Md

24. FUNERAL DIRECTOR: Sermon Bros. ADDRESS: 1661-9th Place Rd SE, Wash DC
25a. REC'D BY REGISTRAR DATE: AUG 15 1966
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11630

CERTIFICATE OF DEATH

11624

1 (M) (C)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

6-251494

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital of Silver Spring

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9303 Glenville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carolyn — Middle: A. — Last: Puopolo

4. DATE OF DEATH: Month: August — Day: 27, — Year: 1966

5. SEX: F — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/20/66 — 9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days: 7 — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francesco J. Puopolo
14. MOTHER'S MAIDEN NAME: Betty E Seguin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Father — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Palsy — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 20, 1966, to Aug. 26, 1966 that (I) (we) last saw the deceased alive on Aug. 26, 1966, and that death occurred at 12:45 M, from causes and on the date stated above.

22a. SIGNATURE: Richard J. Hollander — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Richard J. Hollander
22d. ADDRESS: 1110 Spring St. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/29/66
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City or Town) (County) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home
ADDRESS: 1331 Rockville Pike Rockville, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 30 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge